MSIS State Anomalies/Issues: All States

State	File Type	Record Type	Issue
AK	Claims	Capitation	There aren't any capitation claims as state doesn't have a managed care program.
		Encounter	Except for a few EPSDT encounter claims, there aren't any encounter claims as the state doesn't have a managed care program.
		IP	About 20 percent of the claims are Indian Health Service and therefore don't have ancillary codes as they are not billed on a Uniform Hospital bill (UB-92) form.
		LT	There is a lower than expected percent of claims with patient liability.
			There aren't any claims with a type of service of ICF/MR or Mental Hospital/Aged as these are not covered.
			The average Medicaid amount paid per day is about two times higher than expected, but is consistent across years.
			AK has a low percentage of NF claims in the LT files as they have a relatively low senior population and an active waiver program. They also have a state operated Pioneers Home system, separate from Medicaid, that provides services to many people who might be served by Medicaid NF institutions.
			Some diagnosis codes are padded with zeros on the right as this is how providers sent in the claims. The most common code with padded zeros is 311 (31100 & 3110). This situation was significantly improved starting with Quarter 2 (Q2) 2003.
			At least half the claims have a type of service of Inpatient Psychiatric Under 21 years which is much higher than expected.
		RX	About 5 percent of the claims have a service code instead of National Drug Code (NDC) in the NDC field.
			AK started reporting Indian Health Service as a program type in Q2 2003.
			The Point of Service (POS) system results in few adjustments.
			The date prescribed is always missing.
			There are only a few claims with Third Party Liability (TPL).
			There aren't any claims with a type of program of Family Planning (FP).
		Service Tracking	AK is not submitting any service tracking claims.

State	File Type	Record Type	Issue
AK	Eligibility	CHIP Code	Roughly 400-1000 M-CHIP eligibles under age 21 are mapped to MAS/BOE 35 each month. This could be an age sort issue. Alaska reports its M-CHIP eligibles in MSIS. The state does not have an S-CHIP program. Beginning in FY 2001, there is a higher than expected discrepancy between MSIS and SEDS CHIP counts. It appears that the SEDS data are more reliable. The data become comparable in FY 2003 Q3.
		County Code	Alaska's county codes do not follow the usual pattern of 3-digit odd numbers. However, they are correct.
		Dual Eligibility Flag	About 82-85 percent of persons age 65 and older are dual eligibles. This is a lower proportion than expected. Alaska reports very few QMB and SLMB onlies (dual flags 01 and 03, respectively). In Alaska, the state supplement income standard is approximately 110 percent of poverty for a single individual, and 122 percent of poverty for a couple. Hence, the vast majority of QMB and SLMBs are eligible for full Medicaid benefits by virtue of their eligibility for the state supplement to SSI.
		Health Insurance	More than 40 percent of AK's Medicaid population is enrolled in a private health insurance plan. This is much higher than we see in other states. It happens because of a high percentage are Native Americans and eligible for coverage under the IHS.
		Managed Care	No one in Alaska's Medicaid population is enrolled in a managed care plan.
		MAS/BOE	Alaska has a 6 months continuous eligibility guarantee for children. New enrollment for children is highest in the fall (August and September). July is a peak employment time in Alaska, contributing to a decrease in Medicaid enrollment each July. AK's data show a slight seam effect, with enrollment lowest in month 1 of each quarter.
		TANF/1931	There appear to be problems with the TANF flag, particularly in FY 2001 and FY 2002, when the state reports many more TANF enrollees than ACF data suggest. There was a smaller, though still considerable, discrepancy in FY1999 and FY 2000. The state began 9-filling its TANF data in FY 2003. Once the state's new system (the contract for which is currently under protest) is in place (estimated to occur in September 2004), the state will be able to report TANF data

State	File Type	Record Type	Issue
AL	Claims	Encounter	AL has a prenatal/delivery managed care type program. They are not submitting capitation payments for people enrolled in this program. They pay global fees that are included in the IP file as Fee for Service (FFS). They can be identified by the first 2 bytes in the provider ID number. These claims should be in the OT file as capitation claims. The state has been asked to make that change.
		IP	Patient status is frequently missing. There is a high proportion of crossover claims because most non-crossovers are enrolled in managed care. There is a sudden increase of IP as the result of the state adding in global payment claims for people enrolled in prenatal/delivery managed care. AL requested they be coded as FFS claims as they are based on services provided. They can be identified by a '58' in the first 2 positions of the Provider ID field. These claims are not billed on the UB-92 and so are missing data elements such as UB-92 Revenue Codes, diagnosis and procedures.
		IP, LT, OT	On some claims in Q1 1999, the diagnosis codes are padded with an extra zero.
		IP/LT	In 1999-2000, some of the adjustment claims had an extra character in the 20th position of the MSIS ID. This needs to be removed in order to link with the PSF. This situation was fixed starting with Q1
		IP/LT/OT	Starting in Q2 2000, AL coded most credit claims as crossovers (by 0 filling the coinsurance/deductible fields). AL is going to fix starting with Q1 2003.
		LT	Some facilities bill for more than a month, resulting in some claims having more than 31 covered days. Very few claims have TPL. No claims have Leave Days in 1999. Starting in 2000 they are reported, but the percentage of claims with leave days varies widely by quarter from 3 percent to more than 25 percent. The state reports this is correct. There aren't any claims with a Type of Service (TOS) of IP Psych. < 21. Only about 1/3 of the claims have Nursing Facility Days in 1999.
		OT	The state did not start submitting individual PHP capitation claims until 2001. However, those PHP capitation claims contain the MC plan beneficiary ID and not the MSIS ID. The state will have to resubmit these files correcting this problem.

State	File Type	Record Type	Issue
AL	Claims	OT	AL starting including individual PHP capitation claims in 2001, but the MSIS IDs on those claims are actually plan IDs and do not match the MSIS EL files. AL has been asked to resubmit those claims with the proper MSIS ID. There are only a very few Health Maintenance Organization (HMO) capitation claims with a very low average payment. The credit adjustment claims do not include the service code, making it very difficult to properly adjust the claims.
		RX	Very few claims have TPL in 1999. It appears that the adjustment sets sometimes have the original claim and a resubmission without a void. RX claims with a TOS of '19' are for Clozapine Support System - This is a kit, used to monitor the blood of individuals using Clozaril (a drug with significant negative side effects). The NDC code on these claims is "CLOZSS". effects)
	Eligibility	1115 Waiver	Beginning in FY 2000 Q4, Alabama implemented a new 1115 Waiver. This 1115 welfare waiver provides family planning services for Plan First families. Alabama had an 1115 Waiver program (the Mobile County BAY Health Plan) that was active in FY 1999. The program was terminated, however, on 9/30/99.
		CHIP Code	Alabama reported its M-CHIP children, but did not report any of its S-CHIP children (a much larger program). In FY 2001, M-CHIP enrollment declined and enrollment phased out by FY 2003 Q1. AL did not ever report its M-CHIP program in SEDS.
		County Code	Alabama assigns county code 100 to its Foster Care recipients.
		Dual Eligibility Flag	More than 16,000 eligibles in FY1999 Q1 incorrectly received the dual code 08. They should have been coded as 09s. This change was made in subsequent quarters. Through November 2002, AL assigned dual flag 00 ("not Medicare eligible") to approximately 5,000 persons in MAS/BOE 31-32. These persons should have received dual flag 07 ("QI-2"). The QI-2 program was discontinued in December 2002. Through FY 2003 Q3, AL assigned dual flag 02 ("QMB & full Medicaid coverage") and 04 ("SLMB & full Medicaid coverage") to about 18,000 persons in MAS/BOE 32. These persons should have been assigned dual codes 01 ("QMB-only") and 03 ("SLMB-only"). The state will fix this problem beginning in Q4 FY 2003.

State	File Type	Record Type	Issue
AL	Eligibility	Dual Eligibility Flag	There appears to be a switch for duals with code 01 and 02 (QMB onlies and QMB pluses) between FY1999 Q1 and Q2. Roughly 5,000 duals who are reported with dual flag 01 in Q1 are reported with dual flag 02 in Q2 and beyond. There are no dual eligibles with dual flag 04 (SLMB plus full Medicaid) in FY1999 Q1. Beginning in FY1999 Q2, about 5,500 individuals with dual code 04 are reported each quarter.
		Managed Care	The United Medicare Complete is classified by the state as an HMO for dual eligibles. But the average capitation rate is only $15 indicating that it is very limited coverage. In FY 2000 Q1, about 40,000 eligibles were no longer enrolled in a comprehensive managed care plan. According to the state, these persons were children in Mobile County who were enrolled in the Bay Health Plan. The plan was discontinued and the children moved into Primary Care Case Management (PCCM) plans. More than 300,000 eligibles received PLAN TYPE 08 each month. These persons were enrolled in what Alabama refers to as its "PHP Network." This is not a comprehensive managed care plan. Rather, the PHP Network provides only inpatient care for persons who do not have Medicare Part A coverage. Although disparities exist between CMS and MSIS Medicaid managed care counts, Alabama assures us that the MSIS counts are more accurate. AL has a comprehensive managed care program for dual eligibles called United Medicare Complete.
		MAS/BOE	In the first month of FY 2001 Q1, enrollment in MAS/BOE 35 increased by about 5,000 before returning to its previous level in the following month. The jump in enrollment represented the added enrollment of about 5,000 women into a family planning program. Most of the woman elected not to remain enrolled beyond the first month. There were nearly 800 persons in state-specific eligibility group L who were incorrectly mapped to MAS/BOE 11 and 12 in FY1999 Q1. They should have been mapped to MAS/BOE 31 and 32. This problem was corrected in subsequent quarters.
		Restricted Benefits	Effective Q4 FY 2000, persons in MAS/BOE 55 only qualify for family planning benefits. These persons are assigned restricted benefits code 4.
		SSNs	In Q4 FY 2001, about 850 SSNs were assigned to more that one person. This occurred because both correct and incorrect MSIS ID numbers were submitted with the same SSN. This problem cannot be fixed without resubmission of the entire file.

State	File Type	Record Type	Issue
AL	Eligibility	State-Specific Eligibility Group	Alabama reports a four-byte state-specific eligibility group. Beginning in FY 2000, the deprivation code (bytes 3-4) became unreliable for eligibles in MAS/BOE 14-15. The information in these bytes comes from an external department in the state (DHR). These problems do not affect MAS/BOE mapping during the year.
		TANF/1931	Alabama experienced major problems with its TANF flag in FY 2000 and FY 2001. As a result, the monthly TANF information was not reliable. The state fixed the flag in FY 2002.

State	File Type	Record Type	Issue
AR	Claims	Adjustments	Claims that are voided & resubmitted may not always be tied to original claims resulting in some sets of originals and resubmission may be left in the file.
		IP	Each claim can only have a maximum of 2 diagnosis codes.
			There aren't any claims with a program type of family planning.
			The state doesn't use Diagnosis Related Groups (DRGs).
		LT	The patient liability is not included.
			There aren't any claims with a type of service of Mental Health Aged
		OT	The UB-92 codes on hospital Outpatient Department (OPD) claims are invalid or missing.
			In 1999-2002, AR submitted one PCCM capitation payment claim per month for everyone enrolled in Medicaid, not just for the PCCM enrollees. This will be corrected starting with the Q1 2003 file.
		RX	The few FFS debit claims appear to be all, or mostly, service tracking claims. The state has been asked to correct. The credit adjustments are all individual claims.
			A larger than expected percent of claims have days supply greater than 30.
	Eligibility	1115 Waiver	Arkansas has an 1115 Waiver program called ARKIDS B (called ARKIDS First when implemented in 10/97) and is reporting many of its poverty-related children into MAS/BOE 54. The adults in MAS/BOE 55 only qualify for family planning benefits.
		CHIP Code	Arkansas reports more M-CHIP enrollees in MSIS than in CMS's SEDS system. The state believes the SEDS data is more reliable and is working towards improvement of the MSIS data.
			Arkansas reports its M-CHIP eligibles in MSIS. Its M-CHIP program covers only older children to 100 percent FPL. By FY 2001 Q4, all children turned 18 and were reported as adults. The state has also been approved to establish an S-CHIP program using 150-200 percent FPL. At the same time it is expected to reduce its FPL level for 1115 children from 200 to 150 percent, except for a few children not qualifying for S-CHIP.
		Dual Eligibility Flag	The Arkansas coding for disabled dual eligibles was not reliable until FY 2003. Roughly 60 percent of disabled eligibles were reported as dual eligibles. This is much higher than expected.

State	File Type	Record Type	Issue
AR	Eligibility	Health Insurance	Until Q1 FY 2002, less than 50 eligibles are reported to have private health insurance each month. Less than 0.5 percent of eligibles have private health insurance. This is much lower than expected, but the state confirmed that these data are correct. However, the level increases to over 1000 enrollees per month in Q1-2 FY 2002, before dropping to about 200 per month in Q3.
		Managed Care	Arkansas reports PCCM enrollment in MSIS, however it only reports PCCM enrollment for children in its ARKids program (MAS/BOE 54). This is a significant under-count (about 20 percent of total PCCM enrollment). The state is not reporting any transportation-related managed care in its MSIS data. CMS managed care data show over half of AR Medicaid enrollees participating in PCCMs and a transportation PHP.
		MAS/BOE	After FY 2000 Q3, Arkansas' enrollment data are always highest in month 1 of each quarter and then declines in months 2-3. Recent discussion with the state has indicated that they are not submitting retroactive records, as expected. Roughly 3 percent of the eligibles in BOE 1 are younger than age 65. Similarly, roughly 25 percent of eligibles in BOE 5 are younger than 21. Both proportions are greater than expected.
		Restricted Benefits	Persons in MAS/BOE 55 should have been assigned restricted benefits code 5 (other) since they only qualify for family planning benefits.
		TANF/1931	The TANF flag is 9-filled for all eligibles.

State	File Type	Record Type	Issue
AZ	Claims	All	Since most people are enrolled in plans, FFS distributions are not always as expected.
		Crossovers	There are very few crossover FFS claims. This is because most dual eligibles are enrolled in managed care.
		Encounter	There aren't any claims with TOS 04. It is possible that all MH claims may not be in file. Some IP psych. claims may be in the IP and not the LT file.
		IP	About 1/4 of the claims are missing UB-92 revenue codes as they are Indian Health Service claims.
			There aren't any claims with a program type of family planning due to special population in FFS.
		LT	Beginning in 2001 all LT claims were mostly only paid in month 3. The state has no explanation, but believes all claims paid in each of those quarters are included in the files.
			There aren't any claims with TPL due to small FFS population and the percent of claims with patient liability is lower than expected.
			The files includes mostly claims with a type of service of NFS and only a few ICF/MR (depending on the quarter).
			Beginning Q2 2002, AZ is unable to provide the IP covered days for type of service 04 (IP Psych < 21). There are very few claims with this type of service.
		OT	There aren't any Federally Qualified Health Center (FQHC) claims because AZ doesn't have a FQHC program.
			There was a big increase in the average amount paid between 2000 and 2001 for Physician and OPD services. The state hasn't any explanation except volatility probably due to most people being
			In the 1999-2003 OT files, AZ put the total amount paid on the header of OPD claims on each line item as the line item amounts paid are not available. This means that the payment is overstated by the number of line item claims. Starting in 2004, the Medicaid Amount Paid will be submitted on a summary claim for OPD claims and then each line item will have the service detail but $0 amount paid.
			The ETR is set at 100 percent for Diagnosis 1 but 95 percent or more of the claims actually have a diagnosis.
			The amount charged is mostly missing.
			The percent of local service codes went from 25 percent in 2000 to 50 percent in 2001.

State	File Type	Record Type	Issue
AZ	Claims	OT	The percent of OPD claims with UB-92 codes went from almost 100 percent in 2000 to 36 percent in 2001.
			There aren't any FFS or encounter claims with a Program Type of Waiver Services. AZ says that waiver services are being provided as part of managed care.
			There was a big increase in the percent of OPD claims from 2000 to 2001. The state investigated and has no explanation.
			AZ sometimes makes multiple capitation payments per person/month/plan to cover different plan services.
			All capitation payment claims are coded as crossovers until Q1 2003.
			AZ stopped sending Physician Specialty codes in Q3 1999.
		RX	The prescribing physician ID and TPL amount are always missing.
			AZ had problems with their RX claims processing resulting in substantial changes in claims counts and amounts paid. It is expected this will be corrected in 7/02.
	Eligibility	CHIP Code	Arizona is not assigning a CHIP flag to its child S-SCHIP population. The state does not have an M-CHIP program.
			State groups 325 and 327 are for S-SCHIP parents (100-200 percent FPL), groups probably not reported in MSIS.
		Dual Eligibility Flag	Arizona shifted many dual eligibles from 01 (QMB-only) to 02 (QMB-plus, or full Medicaid) between FY 2001 Q2 and Q3.
		Foster Care	AZ under-reported foster care enrollment in Q1 and Q2 1999. The problem was fully corrected in subsequent quarters.
		Health Insurance	In FY 1999, Arizona acknowledged that the number of persons with private health insurance was lower than it should be. They are making improvements to their TPL file, and the reporting increased somewhat in FY 2000.
		Managed Care	In Arizona, Plan Type 08 is used primarily to cover new eligibles who have not yet selected a managed care plan.
			In FY 2001, CMS Medicaid managed care data showed higher HMO enrollment than MSIS; however, the CMS data included S-CHIP managed care enrollment, while S-CHIP children were not included in the MSIS counts. In FY 2002, the variation between the sources is within the expected range.

State	File Type	Record Type	Issue
AZ	Eligibility	Managed Care	AZ did not report enrollment in Behavioral Health Plans from FY 1999-FY 2002. According to CMS data, there were about 50,000 BHP enrollees in AZ in June, 2002. The state began reporting BHP enrollment in FY 2003. However, the state had been submitting BHP Claims to MSIS all along.
		MAS/BOE	Effective FY 2000 Q3, eligibles in Arizona were assigned one and only one BOE during the year. Thus, people aging out of BOE 4 are not moved into BOE 5. Arizona reported increased enrollment in MAS/BOE 14-15 during FY 2000, attributable to a rapidly growing number of 1931 eligibles not receiving TANF benefits. Effective FY 2002 Q4, AZ extended full Medicaid benefits to the aged with income <100 percent FPL (reported in group 372). Beginning in April 2001, AZ extended full Medicaid coverage to single adults and childless couples in MAS/BOE 55. Between FY 2001 Q3 and Q4, Arizona had a considerable amount of shifting between MAS/BOE groups. The shifts stemmed from the introduction of new Key Codes, as well as a new hierarchy for determining Medicaid eligibility. During FY 2002 Q1-3, growth continued across several of the child and adult groups. State groups 585 (<100 percent FPL), 587 (<40 percent FPL) and 595 (spenddown to 100 percent FPL or less) are for adults with no children who are not otherwise eligible for Medicaid. These groups are part of the 1115 expansion waiver.
		Restricted Benefits	AZ extends family planning only benefits to some persons in group 960. However, the state did not assign restricted benefits code 5 to these individuals until FY 2003.
		TANF	Almost no one was flagged as a TANF recipient from Nov. 99 to Sept. 00. The state corrected this problem in FY 2001.

State	File Type	Record Type	Issue
CA	ALL	MSIS ID	There are about 500,000 people in the CY 1999 MSIS files that have claims, but no EL record. These are mostly preemptively eligible pregnant women. If they are later deemed to be eligible for Medicaid, they are assigned a new Medicaid ID that does not link back to the Temp ID.
	Claims	All	MSIS ID is missing on a few claims
		Capitation	The capitation claims for the hybrid PCCM program are reported with a TOS of PCCM capitation, even though the state is now reporting that enrollment as 'Other MC'. The capitation payment is $2.
		Encounter	Encounter records in all claim types, but encounter data not complete
		IP	Maximum of 2 diagnosis codes
			DRG missing as not used for reimbursement
			Procedure codes 3-6 not available from state
			The percent of claims with a patient status of 'still a patient' is higher than expected. This is perhaps due to the inclusion of Short/Doyle facilitates.
			25 percent without UB-92 codes because of Short/Doyle and LA waiver hospitals. Claims may belong in LT file.
		LT	Diagnoses 2-5 not available in state file.
			The percent with patient liability is lower than expected.
		OT	OPD claims have service codes, not UB-92 revenue codes
		RX	There are many claims in the RX file with state defined service codes in the NDC field that have a length of 7 or less. Those are valid codes defined in CA's MSIS application service code attachments.
			The NDC field is 12 byte '8' filled for crossover drug claims as the NDC in unknown.
		Waiver	Very few waiver claims, but state confirms that is correct. Detailed services not included.
	Eligibility	1115 Waiver	California introduced a very large 1115 Welfare Waiver program (FPACT) in December 1999, which covers family planning benefits for working age women. Enrollment immediately exceeded 1 million persons.
		BCCA	Effective Q2 02, CA begins to report women in the BCCA group.

State	File Type	Record Type	Issue
CA	Eligibility	CHIP Code	California reports its M-CHIP enrollees, but not its S-CHIP population. Additionally, some M-CHIP enrollees in state-specific eligibility groups 7C, 8N, and 8T are correctly mapped to MAS/BOE 44. These children are undocumented aliens eligible for emergency services only.
		Date of Death	All dates of death are 8-filled or 9-filled
		Foster Care	In July and August 2001, there is an unusual dip in foster care enrollment.
		HIC Number	In FY 1999, about 10,000 dual eligibles have missing HIC numbers. This field should be 9-filled in the event that the HIC Number is missing. This problem was corrected in FY 2000.
		Managed Care	In addition, beginning with FY 2000, CA reports enrollment in several hybrid PCCM plans in plan type 8 (other) since these are limited risk contracts and not true PCCMs. However, these are reported as PCCMs in the CMS report. California reports 4-5 million enrollees in dental PHPs each month. Only about 300,000 of these enrollees are reported in CMS counts, however. As it turns out, a small portion of California's dental enrollees are enrolled in "true blue" dental PHPs. These are the persons that appear in the CMS PHP data. The remaining enrollees participate in a hybrid FFS/PHP dental plan. The CMS data do not count these plans as PHPs, but MSIS does.
		MAS/BOE	1931 changes, beginning in FY 2000, are significant. First, CA stopped reporting eligibles into MAS/BOE 16-17 as part of its 1931 changes. Instead, persons who would have been in these groups are reported into MAS/BOE 14-15. Second, some groups previously reported into MAS/BOE 24-25 were moved to MAS/BOE 14-15 as a result of the 1931 changes. Over FY 2000 and 2001, 1931 enrollment grew, while enrollment in MAS/BOE 24/25 declined.
		Race Code	The race field is unknown for 4-10 percent of the Medicaid
		Restricted Benefits Flag	The 1 million FPACT eligibles are only eligible for family planning benefits.
		SSN	Roughly one quarter to one third of eligibles have 8-filled SSNs each quarter. This results in part from the fact that SSNs are not reported for the 1+ million persons who are 1115 FPACT Waiver eligibles. In addition, SSNs are often not available for unborns, newborns, undocumented aliens, and immigrants.
		TANF	TANF status is reported as "unknown" for about 100,000 to 150,000 eligibles beginning in FY 2000 Q1. L.A. county was unable to report TANF status. This continues through FY 2003.

State	File Type	Record Type	Issue
CO	Claims	Adjustments	System change resulted in state being behind in processing adjustments in Q199. Those adjustments showed up in later quarters.
			Some positive credits and negative debits due to the co-pay is deducted from line items.
		Encounter	CO not yet submitting encounter claims, but expects to do so soon.
		IP	There were less than expected number of claims in Q199 due to system change. They occurred in later quarters.
			State recodes HCFA DRGs into state DRGs
		LT	The lower than expected percent claims with patient liability is due to switch from monthly to weekly billing
		OT	The service code is missing on numerous claims because the UB-92 is used for Home Health (HH), waiver, hospice and OPD.
			Lab/X-ray claims have diagnosis codes as that is how they receive them from providers.
			There are very few claims with place of Emergency Room/Emergency Department (ER) in Q1 99 because state didn't start reporting ER separately until Dec 1998.
			CO purchases private health insurance for some enrollees. The premium payments are Type of Claim (TOC) 2 and TOS 19
			There are more claims than expected with $0 because of the way cost sharing is applied
			In December 2003, Colorado's fiscal agent reported that the state has been "redefining" national HCPCS and CPT codes to meet its own needs for many years. Requested copy of redefined codes, as yet not received.
			There are several claims with amount paid = $99,999. This is a valid amount, not improperly '9' filled field
		RX	There are a lot of apparent duplicate claims in the 1999 RX files
			Compound drugs are coded as NDC = COMPOUND
			TPL ERT set at 100 percent, but 25 percent of claims have TPL
	Eligibility	CHIP Code	Colorado's S-CHIP program is not reported in MSIS data. Colorado does not have an M-CHIP program.
		Date of Death	The state does not report dates of death for any eligibles.
		Dual Eligibility Flag	A specific dual eligibility flag code could not be assigned to about 20 percent of the dual population. These persons received dual flag "09".

State	File Type	Record Type	Issue
CO	Eligibility	HIC Number	HIC numbers are 9-filled for about 5 percent of dual eligibles.
		Managed Care	In June 2002, there is a discrepancy between the BHP enrollment count in MSIS compared to the CMS managed care report. Colorado reports that this discrepancy was caused by the state's failure to include two of its BHP plans (Jefferson Center for Mental Health and Access Behavioral Care: Pikes Peak) in the CMS managed care report. The state asserts that its MSIS data is accurate. There is an unusual drop in all types of managed care enrollment (comprehensive, PCCM, and behavioral) in FY 2001 Q2, compared to FY 2001 Q1, Q3, and Q4 and FY 2002.
		MAS/BOE	During FY1999 and FY 2000, Colorado mapped about 4-5,000 disabled individuals into MAS/BOE 32 inappropriately, since they are reported to qualify for full Medicaid benefits. Each month, 50-100 persons were mapped to the invalid MAS/BOE combinations of 19, 39, or 49. CO shows many more SSI recipients in MAS/BOE 11-12 than SSA data, but this may relate to a state-administered SSI supplement.
		Retroactive Records	Colorado decided in April 2000 that they would use the delayed submission, rather than submitting retroactive records. They had initially elected to report retroactive eligibles in their MSIS application.
		SSN	About 8-10 percent of eligibles have the SSN field 9-filled.
		TANF/1931	Over half the children and adults in MAS 1 do not receive TANF benefits, an unusual pattern relative to other states. In FY 2002, the proportion not receiving TANF was about 70 percent.

State	File Type	Record Type	Issue
CT	Claims	Crossover	All crossover claims (IP/LT/OT) are in the OT file for FFY 1999. CT corrected the problem beginning with FFY 2001.
		Encounter	No encounter data submitted
		IP	Q1 2003 - 75 percent of the claims are adjustments.
			The DRG and DRG grouper are missing as not used for
			Chronic disease hospital claims are in IP files. This impacts UB-92, patient status codes and LOS
		LT	The admission date is always missing.
		OT	The percent of HH claims is high because the state is able to submit line item services instead of just a summary bill.
			The percent with office place of service is lower than expected because it is not reported on HH claims and there are a large number of those claims.
			In 2004 Q1 there is a big drop in the average Medicaid amount paid on original, FFS, non-crossover claims with a type of service of lab, Other Practitioners, Other Services and Program Type Home- and Community-Based Services (HCBS). That was the first quarter of a new system.
			There are a few state-specific codes that have more than one definition, but the state service code indicator
		RX	Date prescribed missing
	Eligibility	CHIP Code	Connecticut is not able to identify M-CHIP eligibles. Currently, M-CHIP children belong to certain state-specific groups that also include non-CHIP children. As a result, these state-specific groups are coded as 9 (CHIP status unknown) for the CHIP indicator. The state does not report its S-CHIP eligibles, either. The M-CHIP program is phasing out. In Q4 FY 2002, M-CHIP enrollment according to SEDS was 1273 person months.
		Dual Eligibility Flag	In FY 2001, enrollment in QMB-only, SLMB-only, and QI programs increased, following a special outreach effort.
		Foster Care	Until Q2 FY 2002, a higher than expected proportion of foster care children were older than age 20.
		MAS/BOE	In FY 1999 and FY 2000, Connecticut exhibited a "seam effect" between the third month of a quarter and the first month of the next quarter. The state reported a large number of retroactive eligibles, however, which presumably smoothed out the seams.

State	File Type	Record Type	Issue
CT	Eligibility	MAS/BOE	In FY 2001, enrollment in MAS/BOE 34 declined, while MAS/BOE 44-45 enrollment increased. This was due in part to changes in financial rules.
		Retroactive/Correction Records	CT had an unusually high number of retroactive and correction records in Q1 and Q2 FY 2003 when it made some system
		SSI	CT is a 209(b) state and only reports about half of the SSI population in MAS/BOE 11-12. Part of the problem is that the state does not report disabled children who quality for Medicaid in MAS/BOE 12.
		SSN	In each quarter of 1999, a few Social Security numbers are "0-filled" or "8-filled." They should be "9-filled" if unknown. Across all years, CT had assigned some SSNs to more than one person.
		TANF/1931	Connecticut cannot identify its TANF population. The field is 9-filled for all eligibles.

State	File Type	Record Type	Issue
DC	Claims	All	TPL missing on all claims, except a very few in the RX file
		Crossovers	There are fewer than expected percent of crossover claims.
		Encounter	No encounter data was submitted
		IP	DRGs are not included on about 35 percent of the claims
			A greater than expected percent of the claims don't have accommodation codes due to partial bills for hospitalizations.
			The average length of stay is about 8 days which is higher than expected. The state confirms it is correct.
		LT	The percent of claims with TOS 02 and 04 is quite variable from quarter to quarter, probably because there are so few of them and also the billing cycle.
			In 2003 Q3, DC was unable to identify crossover claims and since most claims in the LT files are non-crossovers, all the LT claims are reported as non-crossovers.
			Most LT claims have a diagnosis code of 799.9 until Q4 2002 when they are converted to 'unknown'.
			There are no crossover claims in Q4 2002.
			TPL is not reported in the LT files.
		OT	The percent of claims paid in month 1 was very low as this is when the new processor took over.
			There are very few dental claims in the OT file. The state confirms that is correct.
			The average amount paid on clinic claims doubled in Q1 2003 as there were over 61,000 old (1999-2002) DC Family Service claims paid in that quarter. The amount paid on those claims were either $452 or $646.
			All claims with a type of service of OPD have service codes instead of UB-92 revenue codes as they bill using the HCFA 1500.
			There aren't any claims with a Program Type of FQHC.
			There is an increase of about 200,000 claims in Q1 2000. They are mostly clinic claims and the state has no explanation.
			The percent of claims with a Place of Service of Unknown dropped from about 40 percent in 1999 to under 20 percent in 2002.
			The distribution and payment for services varies widely from quarter to quarter. In Q1 2000 one provider submitted lots of old claims.

State	File Type	Record Type	Issue
DC	Claims	OT	There are fewer waiver claims then expected, but the percent increased slightly in 2000.
			There were about 100,000 more claims in 1999 Q2 than in the other 3 quarters of the year.
			The average Medicaid amount paid for all services was slightly higher in Q2 1999 compared to Q1, Q3 and Q4.
		RX	The date prescribed is always missing.
			There aren't any claims with a program type of family planning.
		Waiver	There are very few waiver claims as DC just started waiver program in 1999. The percent increases in 2000.
	Clains/FFS	OT	In Q4 2000 the state starting submitting claims with state defined service codes.
	Eligibility	CHIP Code	D.C. is reporting its M-CHIP data. D.C. does not have an S-CHIP program. From FY 2000 Q1 through FY 2002 Q2 (except FY 2001 Q1, when the numbers compared well), more M-CHIP children were reported in MSIS that the CMS SEDS system, but DC maintains that the MSIS numbers are more reliable.
		Dual Eligibility Flag	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
			Until Q3 FY 2002, only 85 percent of D.C.'s aged Medicaid population were reported as being dually eligible for Medicaid and Medicare. In addition, D.C. was not able to assign a specific dual eligibility code to 60 - 65 percent of its dual population. Instead, these eligibles were assigned dual code value 09. Also, until FY 2002 Q3, D.C. did not include the following groups of duals in its MSIS data: SLMB-only, QI, QII, QWDI. Information on these eligibles was not retained in the District's MMIS until Q3 FY 2002. Since D.C. provides full Medicaid benefits to 100 percent FPL for the aged and disabled, there are hardly any QMB-only eligibles (about 100).
		Health Insurance	DC reported a lower than expected proportion of eligibles with private health insurance (1.3 - 1.4 percent) until Q3 FY 2002.
		HIC Number	About 20-25 percent of the dual eligible population did not have valid HIC numbers until Q3 FY 2002.
		Managed Care	MSIS reports the "Health Services for Children with Special Needs" plan as an HMO. However, this plan is reported as a "Medical-Only PHP" in the CMS managed care report.
		MAS/BOE	A noticeable increase in aged enrollees occurred in Q3 FY 2002 when DC began reporting several restricted benefit dual groups for the first time.

State	File Type	Record Type	Issue
DC	Eligibility	Retroactive Records	DC stated in its MSIS application that they would be reporting retroactive records. This information is incorrect. They are actually using the delayed submission.
		SSI	Relative to the number of aged and disabled SSI recipients, DC reported 25 percent-30 percent more eligibles under MAS/BOE 11 and 12 through FY 2001 Q3. This suggests they were covering some aged and disabled under Medicaid as SSI recipients who no longer received SSI benefits. Effective FY 2001 Q4, this problem begins to
		SSN	About 3 percent of eligibles do not have valid SSNs.

State	File Type	Record Type	Issue
DE	Claims	Adjustments	There are very few adjustments (<1 percent). DE confirms this is correct.
			There are no adjustment claims in the 2002 Q4 or 2003 Q1 IP file due to system changes.
		All	DE changed systems in Q4 2002. There are problems with claims for that quarter. Mostly, there is a shortfall of claims and a significant shift in the type of services reported and average amount paid for some services. DE believes that this will be remedied in future
		Capitation	There aren't any PCCM capitation claims in the OT file as case management is paid on a FFS basis and not a monthly payments.
			There aren't any PCCM capitation claims because PCCM providers are paid on the basis of services provided, not a capitated rate.
		Crossovers	Beginning with Q4 2002, DE will begin submitting OT XO claims with one record per line item, without Medicaid Pd, Coinsurance/Deductibles, and Charge as those amounts are only carried on the header. They will submit a separate header claim with those summary amounts.
		Encounter	There was a 50 percent drop in the number of encounter and capitation claims between the first and second quarter. This was due to the change in claims processors by one plan and the fact that sometimes capitation payments are made for 2 months at a time.
			The files contain a lot of encounter claims but the completeness of the submission is unknown.
		IP	The state pays for bundled services for Services for Children, Youth and their Families (DSCYF) that includes inpatient care. These claims do not have UB-92 revenue codes, patient status or admission date. The number of these bundled claims nearly doubled between Q1 and Q2 1999.
			There aren't any claims with Program Type of Family Planning.
			The percent of claims without UB-92 codes declined in 2000.
			There weren't any claims with a Patient Status of Still a Patient until 2002.
			DRGs are not included as they aren't used for reimbursements.
		LT	There are not any covered days on claims with a type of service of
			TPL is missing on all claims.
			There was a big increase in adjustments in Q2 1999 as that is when the claims are adjusted to accommodate rate changes.

State	File Type	Record Type	Issue
DE	Claims	OT	There was a change in the distributions on some types of service from Q1 to Q2 1999 due to inconsistencies in submission of bills. Also, prior to January 2000, people with private health insurance were not allowed to enroll in managed care. About 2000 people were moved to managed care as a result of the rule change.
			For some reason, the average expenditure for clinics doubled in Q4 2000.
			The files do not contain any claims with a Program Type of FQHC.
			The place of service of ER is much lower than expected
			Place of service is missing
			Claims with a TOS of Transportation make up between 26-40 percent of all services. Starting with Q1 2003, there will be a transportation managed care program.
		RX	Compound drugs are all reported as COMPOUND
			Date prescribed & refill indicator are missing
		TPL	There aren't any claims with TPL as it is a 'pay & chase' state
	Eligibility	CHIP	Delaware's S-CHIP program is not being reported into MSIS.
			In Q4 FY 2002, DE added an M-CHIP program for infants 186-200 percent FPL.
		Dual Eligibility Flag	Initially, Delaware had difficulty coding the dual eligibility flag at the level of detail requested. QI1s and QI2s were reported as SLMB onlies (dual code = 03), although some sporadic QI reporting occurred in FY 2000-FY 2002. Also, Delaware had difficulty identifying some full QMBs and full SLMBs. These dual eligibles were categorized as Medicare eligibles whose reason for Medicaid eligibility is unknown (dual code = 09).
			DE moved to a new MMIS system in Q3 FY 2002 with EDS. They hope to be able to report QI1s consistently by FY 2004.
		Managed Care	From FY 1999-FY 2002, the majority of eligibles were enrolled in two HMOs as part of the state's 1115 demonstration. However, DE began to report PCCM enrollment as well in Q4 FY 2002. Also in Q4 FY 2002, the number of HMOs dropped to one.

State	File Type	Record Type	Issue
DE	Eligibility	MAS/BOE	Effective 1/02, DE began to change its coding so that only TANF and 1931 eligibles (state group 71) were reported to MAS/BOE 14 and 15, while transitional assistance eligibles (state group 81) went to MAS/BOE 44 and 45. Since transitional assistance eligibles were previously reported to MAS/BOE 14-15, this caused an increase in MAS/BOE 44-45 enrollment in Q2 FY 2002. However, in Q3 and Q4, enrollment in MAS/BOE 14-15 expanded due to growth in the 1931 program. During FY 1999, several changes occurred in eligibility mapping and eligibility policy which make it difficult to track Delaware's eligibility counts by MAS/BOE group for FY 1999. For Q199, Delaware reported some 1931 eligibles to MAS/BOE 44/45 since they were included with transitional assistance eligibles in aid category 81 (all 1931 eligibles should have been reported into MAS/BOE 14/15). Then, effective 1/99, the state started using a new classification approach for eligibility. In the new classification approach, all 1931 eligibles were correctly reported into MAS/BOE 14/15. However, transitional assistance eligibles were also reported into MAS/BOE 14/15 effective 1/99 (instead of MAS/BOE 44/45). As a result of these changes, the number of eligibles in MAS/BOE 44/45 sharply declined in Q299. Researchers should be aware then that the types of eligibles mapped into MAS/BOE 14/15 and 44/45 are not consistent during 1999. Further complicating any analysis, the state expanded its interpretation of 1931 eligibility rules beginning in 1999. As a result, the number of children and adults reported into MAS/BOE 34 and 35 declined somewhat in Q2, while the numbers in MAS/BOE 14 and 15 appeared to grow by a commensurate amount. The patterns finally stabilized in Q3 and Q499. Over time in FY 1999 and FY 2000, as a result of the 1931 expansion, we see an increasing number of eligibles in MAS/BOE 14-15 who are not TANF eligibles. Delaware's 1115 Waiver program extends full Medicaid benefits to adults with income to 100 percent FPL. It also extends family planning benefits (only) for 24 months to women leaving Medicaid. Initially, a few groups could not be correctly mapped to MAS/BOE due to coding contraints. These include eligibles in 1619(b), some foster care children, and some 1931 eligibles. However, the state fixed its 1931 reporting effective 1/02 and began to report 1619(b) eligibles (state group 20) in Q4 FY 2002.
		Restricted Benefits	Enrollees in state group F3 (in MAS/BOE 54-55) are assigned restricted benefits code 5 (other). They only qualify for family planning benefits.
		SSN	A few SSNs were 0-filled in FY 1999 and FY 2000. They should be 9-filled.

State	File Type	Record Type	Issue
DE	Eligibility	TANF	Beginning with Q4 FY 2000, DE 9-fills TANF status.

State	File Type	Record Type	Issue
FL	All	MSIS ID	The MSIS IDs on the claims and most of the EL records are 9 bytes, with a check digit in the 10th position. There are a few EL records with a 9 byte MSIS ID. The check digit was not always set the same between claims and eligibility. Since the 9 byte MSIS ID uniquely identifies enrollees, the EL file can be unduplicated by dropping the 10th byte, sorting the file by the 9 byte MSIS ID and dropping the duplicate records. The claims files can be made to link correctly with the EL files by dropping the 10th byte as well.
	Claim/FFS	IP	In 2003 the percent of claims without ancillary codes is higher than expected.
	Claims	Encounter	There are no encounter records on the files.
		IP	21 percent of the claims on the Q1 1999 file are original claims. This percentage is lower than expected, and is because of a large number of adjustments in the first quarter.
		LT	The patient status, diagnosis code and admission date are missing on nearly all of the claims. There aren't any claims with a type of service 04 - inpatient psychiatric services - under 21.
		OT	There a lower than expected percentage of crossover claims in the In 1999 26 percent of the original, non-crossover FFS claims have a place of service of '99': Other or Unknown. There is a problem with the reporting of non-crossover FQHC claims in the Q3 2003 file. It appears that it is a problem with the reporting of crossovers and not FQHCs. FL plans to fix and resubmit.
	Eligibility	CHIP Code	Florida reports enrollment in its M-CHIP and S-CHIP programs. The enrollment reported in its S-CHIP program, however, is incomplete and only for eligibles ages 1-5 who have transferred from Medicaid. The M-CHIP program appears to be phasing out.
		County Code	Florida used state county codes instead of FIPS county codes in FY1999 and FY 2000. The state has supplied MPR with a crosswalk that links together their state codes with the FIPS codes.
		Dual Eligibility Flag	Florida has a slightly lower than expected number of aged dual eligibles, which may result from the state's large immigrant Florida extends full Medicaid benefits to the aged and disabled with income below 90 percent FPL, accounting for the somewhat lower than expected proportion of QMB-only dual eligibles.

State	File Type	Record Type	Issue
FL	Eligibility	Eligibility Group	Enrollment in the SLMB state-specific eligibility groups "SLMBA," "SLMBD", and "SLMB" drops from about 21,000 total at the end of FY 1999 to 14,000 total at the beginning of FY 2000. Enrollment stays at this level until the beginning of FY 2001 when it jumps to around 30,000. The state acknowledges this problem, but is unable to explain it.
		HIC Number	Roughly 3,300 dual eligibles have blank HIC numbers in FY1999 Q1.
		Managed Care	Florida generally codes enrollees in its MediPass plan to Plan Type 07 (PCCM). However, enrollees with mental health MediPass providers are coded to Plan Type 03 (BHP). This can be confusing, since these BHP/PCCM providers are listed on the PCCM Provider ID file, not the regular Managed Care Provider ID file. Although MSIS reports fewer enrollees in Plan Type 03 than CMS reports in its PHP count, the state has assured us that the MSIS figure is accurate. Each month in FY1999, a few hundred ineligible persons (who are mapped to MAS/BOE 00) received PLAN TYPE = "88" and PLAN ID = "88888888888". Persons who are ineligible for Medicaid during a month should receive PLAN TYPE = "00" and PLAN ID = "000000000000."
		MAS/BOE	Florida reports roughly 10-15 percent more SSI eligibles (in MAS/BOE 11 and 12) than does SSA over the same period of time. In Q3 FY 2002 persons in state group MX_D were mismapped to MAS/BOE 94 instead of 44. Women with breast cancer (state group MB_C) were mismapped to MAS/BOE 95 in Q3 FY 2002 and MAS/BOE 35 in Q4 FY 2002. They should be mapped to MAS/BOE 3A In July and August 2002, enrollment in MAS/BOE 22 surged. The state had reduced its income thresholds for the aged and disabled, but litigation forced FL to reinstate individuals who lost eligibility for two months. They were reported into state group NS_D. In all disabled MAS/BOE groups (12, 22, 32, and 42), a sizeable proportion of enrollees are over age 65. Researchers may want to remap these individuals to the aged groups (MAS/BOE 11, 21, 31, and 41). In FY 1999 and FY 2000, the age sort for MAS/BOE 31 was not working properly and about 8,000 individuals under age 65 were mapped to MAS/BOE 31 who should have been mapped to MAS/BOE 32. The state provides full Medicaid benefits for the aged and disabled up to 90 percent FPL. Children and adults in MAS/BOE 54-55 (state-specific group FP) only qualify for family planning benefits.

State	File Type	Record Type	Issue
FL	Eligibility	Restricted Benefits	Children and adults in MAS/BOE 54-55 (state-specific group FP) only qualify for family planning benefits (reported under the "other" code, 5). In addition, persons qualifying through the medically needy provisions are usually assigned the "other" restricted benefits code.
		TANF/1931	Florida cannot identify TANF recipients. All eligibles receive TANF = 9, indicating that their TANF status is unknown.
	Eligibilty	Header	Quarterly Backups and Valids EL files contain more than one (3) header records.

State	File Type	Record Type	Issue
GA	All	All	Some claims don't link with the MSIS ID in the EL file. This is under investigation.
		MSIS ID	The state assigned new MSIS IDs, provider IDs, case numbers and provider specialty codes beginning with Q3 2003. They may be asked to resubmit all Q1 1999 - Q2 2003 files with the new MSIS ID. The provider ID, case number and specialty code will probably not be replaced on the old files.
	Claims	All	Adjustments are not properly coded and won't be fixed until Q2 2003. All adjustments have an adjustment indicator of 1 (void), regardless of the type of adjustment. Starting with the 2002 files, GA will change the Adjustment Indicator to '3' if the Medicaid Amount Paid on the adjustment claim is a negative amount and a '4' if it is a positive amount. This doesn't really fix the adjustment claim problem.
		Encounter	There are no encounter data on Georgia's files.
		IP	GA submitted the DRGs as character instead of numeric. During the Valids edits, if the DRG is character, it is converted to 0. This should be corrected starting with the 2003 files. The DRG codes are on the state backup files, just not the Valids.
		LT	Over 13 percent of the claims have a Medicaid Amount Paid of $0. It is unusual for such a high percentage of original non-crossover claims to have a zero Medicaid Amount Paid. The state has no There are no claims with a TOS of '02' or '04'. This is OK because these are not on Georgia's TOS xwalk. There are no diagnosis codes on the file. Also, very few claims have Leave Days. There is no reported TPL and the percent of claims with patient liability is lower than expected.
		OT	Over one-quarter of the original, FFS claims have a Place of Service of '99': Unknown. There aren't any claims with a Type of Service of PCS.
		RX	The NDC code is missing on a few void claims in 1999-2000 making those claims difficult to adjust properly. That field is either blank or 11 byte 9 filled (instead of 12 byte). There aren't any Family Planning claims.

State	File Type	Record Type	Issue
GA	Eligibility	CHIP Code	Georgia administers an S-CHIP program. S-CHIP enrollees are not reported in FY1999, but they appear in Q1 FY 2000. S-CHIP enrollment is underreported in Q1 FY 2000 and is not reliable. However, in Q4 FY 2000, the total number of eligibles in state-specific groups 90 and 91 (the S-CHIP groups) is within 13 percent of the CMS SEDS count for that quarter. S-CHIP children were mistakenly assigned CHIP flag 0, instead of CHIP flag 3 in Q2-3 2000. In contrast, CHIP flag 3 was mistakenly assigned to almost all records on the Q4 2000 and FY 2002 files. In FY 2001, GA begins fully reporting S-CHIP. However, the MSIS S-CHIP count is much greater than the SEDS count in FY 2001 and the MSIS data are not reliable. In FY 2002, the total number of persons in state-specific eligibility groups 90 and 91 in MSIS is reasonably close to the SEDS count (9-14 percent discrepancy each quarter). GA does not have an M-CHIP program. GA uses Dental Health Administrative Consulting Services (DHACS) to manage its S-CHIP program (called Peach Care). DHACS submits enrollment information on S-CHIP children (in groups 90 and 91) to the state's MMIS system (managed by EDS). In addition, DHACS submits enrollment information on children who apply for S-CHIP, but are found to be eligible for regular Medicaid (group 71). The children in this Medicaid group are called Peach Care Plus, since they qualify for the regular Medicaid benefits package. In FY 2001, two errors occurred in the DHACS reporting to the MMIS. First, monthly enrollment information was not reported. Instead, DHACS reported children who were ever enrolled during the quarter. In MSIS data, these children were shown as enrolled all 3 months of the quarter. Second, children in group 71 identified by DHACS were erroneously counted as S-CHIP children, not regular Medicaid children. In MSIS, they were assigned to MAS/BOE 00 and CHIP code 3, when they should have been assigned MAS/BOE 34 and CHIP code 1. As a result of these errors, Medicaid enrollment is under-counted and S-CHIP enrollment is overcounted in FY 2001. In addition, children in groups 71, 90 and 91 identified by DHACS are reported as enrolled all 3 months each quarter, when they may not have been enrolled the entire quarter. The number of children in group 71 who were erroneously reported as S-CHIP instead of Medicaid ranged from 200 in Q1 FY 2001 to almost 46,000 per month by Q4 FY 2001.
		County Code	In FY 2000 Q1-3, GA over-reported enrollees of state codes 90 and 91 (the state CHIP groups) into county code 009. The reported enrollment levels in 009 returned to normal in Q4 FY 2000. The state acknowledges that code 009 was incorrectly assigned for numerous records in FY 2000 Q1-3 and claims to have resolved the problem through correction records. In FY 2002, GA began assigning even numbered county codes to several thousand enrollees. The state has been asked to explain this.

State	File Type	Record Type	Issue
GA	Eligibility	Dual Eligibility Flag	Georgia codes about 75 to 90 percent of its dual eligible population with Dual Eligibility Flag = 09 (individual is entitled to Medicare, but reason for Medicaid eligibility is unknown).
		HIC Number	Roughly 6-10 percent of non-dual eligibles have valid HIC numbers. This is a higher proportion than expected.
		Managed Care	Each month in FY1999, some eligibles with Plan Type = 01 (comprehensive managed care) have 8-filled Plan IDs. The CMS managed care report includes about 2000 individuals in a Mental Health PHP that is not reported in MSIS because it is a 1915c waiver program. GA's Grady Memorial Hospital HMO ceased 1/00. The MSIS data on PCCM enrollment was consistent with CMS data in FY 2001, but there was a considerable discrepancy in FY 2002 (677,148 in MSIS and 1,043,154 in CMS report). GA has a NET transportation PHP that is not being reported into MSIS. CMS managed care data showed almost 1 million enrollees in the NET program in June, 2002. The state is working towards its inclusion for Q3 FY 2003. The CMS managed care report in 2001 and 2002 includes about 3000 individuals in a Mental Health PHP that is not reported in MSIS because it is a 1915c waiver program. There appears to be a seam effect with the managed care enrollment data, with enrollment lowest in month one each quarter and highest in month three. Then, managed care enrollment falls in month one of the next quarter.
		MAS/BOE	During January to April of 2001, GA reinstated a large group of former TANF recipients into Medicaid in MAS/BOE 14-15, accounting for a short-term dramatic increase in enrollment. Georgia exhibits a seam effect between the last month of one quarter and the first month of the next quarter. Generally, enrollment is highest in month one of each quarter and lowest in month three. This problem also affects other fields, most notably Plan Type. It is improved somewhat by their submission of retroactive eligibles, but not entirely resolved. GA Medicaid enrollment is under-counted in FY 2001 for reasons explained above under "CHIP Code". CMS has requested that GA resubmit the FY 2001 files and correct the under-count before submitting FY 2002 files.

State	File Type	Record Type	Issue
GA	Eligibility	MAS/BOE	In August 2001, GA terminated its special family planning program (state-specific group 77), causing an abrupt decline in MAS/BOE 35.
			In Q4 FY 2001 and in FY 2002, GA mistakenly 0-filled the Plan ID, Plan Type, and restricted benefits fields for about two thousand persons (per month, per field) who were assigned a MAS/BOE other
			Increases in state groups 19 (TANF MAO child/MAS/BOE 44) and 24 (foster care TANF/MAS/BOE 48) in the summer of 2001 are probably related to the TANF reinstatement in January-April 2001.
			In Q4 2000, a few individuals were assigned an invalid MAS of 6 or
		Retroactive Records	Georgia decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	GA has a problem with SSNs assigned to more than one enrollee (for example, 33,677 in Q1 FY 2001) that appears to be caused by outside agencies providing data for the MMIS.
		TANF/1931	Georgia cannot accurately identify TANF recipients. The field is 9-filled for all eligibles.

State	File Type	Record Type	Issue
HI	Claims	All	The 1999-2001 files contain very few adjustment claims and they are all voids with $0 paid. The files that AZ received from HI were supposedly mostly adjusted. They believe that the $0 paid voids, actually had a negative amount paid that wasn't allowed in their system, so they were converted to $0. For this reason, it isn't possible to create correctly adjusted claims. The 2002 files have negative amounts paid on void claims, but the resubmittal claims still have $0 paid. This was fixed starting with the 2003 files. AZ is creating the HI MSIS files. They took over what HMSA had in their legacy files for 1999-2002 and there are many problems/missing information in those files. Starting with 2000, AZ took over the MMIS processing as well and they expect all these problems to be
		IP	TPL is basically not reported in the 1999 files. 1999-2002: It appears that there may be some claims from long stay hospitals in the IP file as about 15 percent of the claims are for people who are still a patient and they are missing UB-92 ancillary codes. Also the average number of days stay is 9 which is higher than expected. Covered days are not reported in the 1999 files. The 1999 files do not have UB-92 Revenue Codes although they are supposed to be in the system. There are a few claims with an invalid patient status. This will be fixed in the 2000 files. Very few of the IP claims in the 1999-2001 files are flagged as crossovers. The state believes they are in the file, but just not identified. The coinsurance and deductible amounts are carried as separate line items. HI expects to fix this starting with the 2002 or 2003 files. 2000-2001: There are about 50 percent fewer IP claims based on comparison to the 2003 Q1 file.
		IP/OT	There are very few claims with a TPL amount and it is always $0 or negative. This cannot be fixed until the 2000 files.
		LT	Charge is always missing in the 1999 files. 2000: There are not any crossover claims. 1999-2001: Leave days are not reported. 1999-2000: There is no patient liability in the files.

State	File Type	Record Type	Issue
HI	Claims	LT	In 2002 there was a huge increase in the number of LT claims without covered days and with a discharge status of 'discharged'. This is a result of the conversion process and are actually old claims for non-bundled services that were not previously included in the file.
			Patient Liability is missing in the 1999-2001LT files. In 2003 it is mostly a negative amount.
			2000: There are very few resubmittal claims and the amount paid is
			No covered days are reported in the 1999 files.
		OT	The switch in 2003 to reporting OPD claims with a summary claim with the total amount paid and line item claims with $0 paid means that there will be an increase in the percent of claims with percent0
			Some of the CPT-4 codes have an invalid length of 7 in 1999.
			There aren't any claims with a Type of Service of HH in 1999.
			The 1999-2002 files do not include waiver claims as they are processed by a different state agency and weren't provided to AZ as input into those files. Claims with a Program Type of Waiver start occurring in the 2003 files.
			2000: There are not claims with a type of service of aged MH or IP Psych < 21.
			There are no UB-92 Revenue Codes on OPD claims in 1999.
			HI OPD claims will be handled the same way as the AZ claims as AZ is doing their processing. That is, there will be a summary OPD claim with the total Medicaid Amount Paid for all line item services and then individual line item claims with $0 paid. This means that there will be a higher percent of claims with $0 paid.
			TPL is not reported in the 1999 files.
			Charge is always missing in the 1999 files.
			2000: The amount paid on adjustment claims (resubmittals) is usually $0.
			The OPD claims don't have UB-92 Revenue codes, even though they are billed on a UB-92 in the 1999 files. This will be fixed in the 2000 files.
			All capitation payment claims are coded as crossovers from 1999 - Q1 2003.
			1999-2002: The files do not include waiver or Rural Health Clinic (RHC) claims.

State	File Type	Record Type	Issue
HI	Claims	OT	The most frequent Service Code in the OT file is Z9020 (taxes). The taxes are carried as separate line items on HI claims. These claims will be included in the 1999 files, but should be ignored except for reporting expenditures. This will be fixed in the 2000 files. The quantity is always missing in the 1999 files. This will be fixed in the 2000 files. Very few of the 1999-2001 claims have a program type of FQHC, however, HI does have FQHCs.
		RX	The quantity is always missing in the 1999 files.
	Eligibility	CHIP Code	Hawaii has an M-CHIP program, but no S-CHIP program. The M-CHIP program did not begin enrollment until January 2000 and didn't appear in MSIS until July 2000.
		Dual Eligibility Flag	Roughly 80 percent of aged eligibles are reported as being duals in FY 2000. This improved to 86 percent by FY 2003. We generally expect everyone aged 65 and older to be dually eligible. In FY 1999, roughly 50 percent of dual eligibles in Hawaii received flags 08 or 09. This proportion fell to less than 10 percent in FY The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. Between 4-5 percent of persons in BOE 4-8 are reported as dual eligibles in FY 1999. We generally don't expect to see any duals in these BOEs. The state corrected this problem in FY 2000.
		HIC Number	In FY 1999, between 54-57 percent of Hawaii's dual eligibles had valid HIC numbers. This problem was corrected in FY 2000.
		Managed Care	Hawaii claims that CMS overcounts HMO enrollment in FY 1999-FY 2000. The state assures us that the MSIS managed care counts are correct. Each month in FY 1999, 100-400 eligibles with Plan Type 88 (Not Applicable) receive valid Plan IDs. Persons with Plan Type 88 should receive Plan ID 888888888888.
		MAS/BOE	Each month in FY 1999, 100-200 eligibles in valid state-specific eligibility groups are mapped to MAS/BOE 00. These eligibles should be mapped to a valid MAS/BOE group. In the third month of FY 1999 Q4, enrollment drops by about 8,000 in MAS/BOE 14 and rises by the same amount in MAS/BOE 34. According to the state, this is a correction of problems in FY 1999 Q1-3. The data in FY 2000 should be consistent with what we see at the end of FY 1999.

State	File Type	Record Type	Issue
HI	Eligibility	MAS/BOE	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
		TANF/1931	Hawaii 9-fills the TANF field for all eligibles.

State	File Type	Record Type	Issue
IA	Claims	Encounter	There are encounter claims only in the IP and OT files.
		IP	There are no family planning claims because family planning is billed as on an outpatient basis on a HCFA-1500.
		LT	The diagnosis code is missing on most claims.
		OT	There are no claims for sterilizations.
	Eligibility	CHIP Code	Iowa reported its M-CHIP children in MSIS. The state did not report its S-CHIP children, however.
		Dual Eligibility Flag	Roughly 85 percent of Iowa's MAS/BOE 11 eligibles (aged SSI recipients) were reported to be dual eligibles. This is a lower than expected proportion.
		Health Insurance	Roughly 15 percent of Iowa's Medicaid population was reported to have private health insurance. This is a greater than expected proportion.
		MAS/BOE	In FY1999 Q1, between 100-180 CHIP eligibles (state eligibility group 920) were mapped to MAS/BOE 64. This problem was corrected in subsequent quarters.
			Around 5 percent of eligibles in BOE 1 are younger than age 65. This proportion is greater than expected.
		TANF	Effective FY01, IA began 9-filling the TANF flag. TANF data for earlier quarters are not reliable.

State	File Type	Record Type	Issue
ID	All	All	There was a change in the MSIS IDs just prior to FFY Q1 1999. Therefore, the linkage with claims and eligibility records from prior quarters will be incomplete.
	Claims	LT	Almost 20 percent of the claims have a type of service of ICF/MR which is much higher than expected.
	Eligibility	CHIP Code	Idaho reports its M-CHIP enrollment. The state does not have an S-CHIP program.
		Dual Eligibility Flag	Idaho reported that only 50-60 percent of eligibles ages 65 and older are dually eligible for Medicare and Medicaid. We generally expect to see at least 90 percent of the 65+ population as duals. Similarly, 22-26 percent of eligibles in BOE 2 are reported as dual eligibles. We expect between 30-55 percent of a state's BOE 2 population would be dually eligible. The state reports that the low number of duals results from the fact that they are not an auto-accrete state.
		Health Insurance	Idaho reports that about 18-25 percent of eligibles have private insurance. This proportion is much higher than in other states.
		HIC Numbers	Because Idaho is an auto accrete state, there is fluctuation in the percentage of duals with valid HIC numbers. The percentage typically ranges from 91 percent to 97 percent, but was as low as 87 percent FY 2002 Q4.
		Managed Care	The state does not have any managed care. They do have PCCMs, however.
		MAS/BOE	Idaho reported a higher than expected (roughly 3-5 percent) number of eligibles in BOE 1 who are under age 65. This problem phases out by the end of FY 2001. However, in Q2 and Q4 FY 2002, the figure was somewhat high again (about 2 percent). There was a 6 percent increase in the number of eligibles in October 2001. The state believes that the increase is the result of economic hardship at that time. In FY 1999, the number of eligibles in MAS/BOE 11 and 12 was roughly half of the number of SSI recipients reported by the SSA. Some difference may result because SSI recipients in Idaho have to apply separately for Medicaid. In addition, State-Specific Eligibility Group 54, which includes SSI eligibles (and some non-SSI eligibles, as well) were mapped to MAS/BOE 42. In FY 2000, the eligibles in state-specific eligibility group 54 were moved to MAS/BOE 12. As a result, the number of eligibles in MAS/BOE 11-12 is more equivalent to the number of SSI recipients if state supplements are considered as well.
		MSIS ID	The state changed their MSIS IDs starting with FFY 1999.

State	File Type	Record Type	Issue
ID	Eligibility	Retroactive Records	Before Q1 FY 2002, ID had a technical problem that prevented their submission of retroactive records. The state submitted a high volume of retroactive records in FY 2002 (about 100,000 each quarter) to compensate. IDs procedure for submitting retroactive and correction records results in lower levels of retros in quarters run shortly after the previous quarter and higher levels when a large time span elapses between submissions. This does not impact data quality, simply the flow of when retros are submitted.
		TANF/1931	Idaho 9-fills the TANF flag for all eligibles.

State	File Type	Record Type	Issue
IL	Claims	Adjustments	There are no crossover adjustment claims due to how their system processes crossover claims.
		All	The number of claims varies by month and quarter due to state billing cycles. There is an especially big drop in the number of claims in the Q1/Q2 2003 files due to a state budget problem that delayed the payment of claims.
		Encounter	The files contain very few encounter claims. IL expects to be include many more soon.
		IP	Procedure code modifier 1-6 is always missing, but since it isn't used for IP anyway, this is not a problem.
			The number of covered days equals the length of stay on only about 17 percent of the records.
			The IP files have a large number of debit claims that do not link to original claims. They appear to be replacements without the original and void claims. These claims are missing some key information such as UB-92 and diagnosis codes.
		LT	TPL is always missing.
			Patient status is always missing
			The average amount paid per day for MH Aged claims is very high. It is likely some of these claims are actually service tracking claims.
			Up until Q3 2001, IL classified claims for Inpatient Psych. Under age 21 with a TOS of NF.
		OT	There are not dental capitation payment claims in any files in 1999. There are very few FFS dental claims until 2002 when they increased to about 3 percent.
			In 2001, the State of Illinois bean to process Delta Dental claims through the MMIS system rather than through the C-13 voucher system. In their 2002 January - March and April through June claims there will be a big increase in Type of Service 09 claims because of the Department processing backdated claims for Delta Dental (back to 3/99). These claims do not have a Diagnosis Code. After the April through June quarterly tape the level of claims for Type of Service 09 - Dental should level off.
		RX	There are no adjustment claims in 1999.
			There are no NDC codes on adjustment claims, making it difficult to properly adjust the files.
			The state has many state-defined NDC codes.

State	File Type	Record Type	Issue
IL	Claims	Serv Flag	The service code flag on some OT and IP records is coded as HCPCS, but the service code is a state-specific code. IL will correct
	Eligibility	CHIP Code	In FY 2001 Q3-4 and FY 2002 Q1-3, MSIS data show more person months of enrollment than SEDS data for both M-CHIP and S-CHIP. The state maintains that the MSIS data are more reliable. In FY 2002 Q4, the two sources became comparable, due to an increase in SEDS reporting. IL is reporting both its M-CHIP and S-CHIP programs.
		Correction Records	In FY 2001, IL submitted about 1800 correction records each quarter that disenrolled persons in the file seven quarters prior. This problem was resolved in FY 2002 Q1. Thus, FY 2000 Q1 is the last quarter to have enrollees erroneously disenrolled through correction records. In FY 2002 Q3-4, some correction records on the file were lost (about 70,000 per quarter). These records were primarily for FY 2002 Q1-3. The state was not able to provide any explanation about
		Dual Eligibility Flag	IL reports a dual code for only 87 percent of its eligibles >64 years.
		HIC numbers	The percentage of duals with valid HIC numbers dropped to 70 percent when IL began its prescription drug waiver in Q3 FY 2002.
		Managed Care	Illinois exhibits a drop in Plan Type 08 enrollment during FY 2000 Q1. At that time, the County Care Total Health Plan pulled out. Illinois reports enrollment in Plan Type 08 (other). These plans consist of Primary Health Providers and Managed Care Community Care Networks (MCCN). These plans provide different services than comprehensive managed care plans. Enrollment in these plans declined by about 7,000 in FY 2000 Q1 when the County Care Total Health Plan closed. These plans appear to be reported as HMOs (not PHPs) in CMS managed care data.
		MAS/BOE	There were two expansions in Q4 of FY 2000 in Illinois -- a Medically Needy expansion and an OBRA 86 expansion (the OBRA 86 expansion covered aged and disabled eligibles to 70 percent FPL; this was later raised to 85 percent). The codes for the expansions were not ready by Q4, however, so those eligibles are lumped in with the Medically Needy expansion eligibles. Beginning in FY 2001 Q1, new groups 11EXP1 and 23EXP1 are mapped to MAS/BOE 31 and 32; groups 11EXP2, 22EXP2, and 23EXP2 are mapped to MAS/BOE 21 and 22.

State	File Type	Record Type	Issue
IL	Eligibility	MAS/BOE	It appears that enrollment in MAS/BOE 31-32 decreased in FY 2000 Q4, in spite of these expansions. There was some offset in MAS/BOE 21-22, however. MAS/BOE 21-22 enrollment may continue to increase in the future. State law requires that the Medically Needy standard be raised to 100 percent FPL effective 7/02. Effective FY 2002, IL implemented two new types of coverage in an 1115 waiver. In the summer of 2002, IL began enrollment in a Senior Care program, extending drug benefits to aged to 200 percent FPL. In the fall of 2002, IL extended coverage to several groups of children and adults. Plus, the state added new S-SCHIP groups (MAS/BOE Because Illinois is a 209(b) state, the number of persons reported into MAS/BOE 11 and 12 is lower than ordinarily expected. Also relevant, IL reports SSI recipients who do not qualify for a state supplement into MAS/BOE 21 and 22 effective FY 2001 Q3. Enrollment in MAS/BOE 14-17 and MAS/BOE 44-45 declined across FY 2001, but was offset by increases in MAS/BOE 34 and 25. This shift was a result of a Department of Human Services initiative to redetermine eligibility. Many recipients were moved from MAS 1 and MAS 4 to either MAS 2 (primarily adults) or MAS 3 (primarily children). In FY 2002, IL experienced several shifts in MAS/BOE enrollment, which the state believes are the result of its move to a new database. The shifts included a decline in MAS/BOE 14-17, which was offset by increases in other groups, particularly TMA enrollees in MAS/BOE 44-45. In addition, there were some increases in 41-42 due to a more accurate reporting of waiver participants.
		Restricted Benefits Flag	Until FY 2002, between 80-93 percent of eligibles with RBF = 4 (restricted benefits on the basis of being pregnant) are mapped to MAS/BOE 34, 35, 44, and 45. We generally expect that at least 95 percent of eligibles with RBF 4 will be mapped to those MAS/BOE groups. By FY 2002, the reporting was in the expected range most months. Also, RBF 4 is always highest in month three of each quarter and then drops abruptly in the first month of the next quarter -- an RBF "seam effect."
		Retroactive Records	Illinois decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	Illinois reports about 5500 SSNs with duplicate records (i.e., two records with the same SSN) in FY 2001 Q4. This problem likely existed prior to this quarter, but we do not have data for those time periods. The level of duplicates reached 9,000 by the end of FY 2002. The state is aware of the problem, but unable to correct it.

State	File Type	Record Type	Issue
IN	Claims	Encounter	The OT, IP and RX files contain encounter claims
		IP	There aren't any claims with a program type of family planning.
			The percent of claims without ancillary UB-92 revenue codes has been increasing over time. It was 2 percent in Q1 2000 to 7 percent in Q4 2000 to 9 percent in Q4 2002.
		RX	The date filled is also in the date prescribed field.
	Eligibility	CHIP Code	IN is reporting M-CHIP into MSIS. Its S-CHIP program was implemented 1/1/2000 and reported into MSIS effective FY 2000Q2.
			In FY 2002 Q4, there is a 25 percent discrepancy between MSIS and SEDS S-CHIP counts. The two sources compare well in other quarters. The state believes that the SEDS numbers are erroneous
		Correction Records	In some quarters, IN has a large volume of correction records. Analysis of Q2 and Q4 FY 2002 corrections showed that the majority of the correction records did not change any key data elements.
		County Code	Indiana submitted files using state county codes instead of FIPS county codes in FY 1999. The state gave us a crosswalk that links together state codes and FIPS codes. This problem was fixed in FY
		Dual Eligibility Flag	IN assigned dual flag 08 to about 22 percent (21,000 persons) of its dual population. Indiana explained that these persons have Medicare Part B, but don't fall into one of the other dual categories.
		Health Insurance	IN reported about 12 percent of its eligibles with private health insurance which is higher than other states report. The state confirmed that this proportion is correct.
		HIC Number	Just over 5 percent of the dual eligible Medicaid population do not have a HIC number.
		Managed Care	In January 2001, two new HMOs were introduced, causing a shift in HMO enrollment by plan.
		MAS/BOE	IN is a so-called 209(b) state. This explains why the total number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by the Social Security Administration. IN reports the SSI disabled over age 64 into MAS/BOE 11.
			During FY 2000, about 500 people were incorrectly mapped to MAS/BOE 01 and 04.
			In Q4 FY 2001, Indiana began enrolling women in MAS/BOE 3A under the BCCPTA provisions.

State	File Type	Record Type	Issue
IN	Eligibility	Restricted Benefits	Approximately 10 percent of aliens with restricted benefits are assigned MAS 4. Typically, we expect at least 95 percent of restricted aliens to appear in MAS 4. IN reports roughly 10,000 restricted aliens each quarter.
		TANF	In FY 2002, there is an 18 percent discrepancy between MSIS and ACF TANF counts.

State	File Type	Record Type	Issue
KS	Claims	Adjustments	The state indicated that there may be originals and then resubmittals without voids. However, it doesn't appear to be that way from the DQ tables.
		Capitation	There are very few HMO capitation claims in the 2002 files, but about 75K HMO enrollees per month. The state has been asked to fix and resubmit.
		Crossovers	There are some claims where the Medicaid Coinsurance/Deductible amounts are not put in the Medicaid Amount Paid field.
		Encounter	There are encounter records in the IP, OT, and RX files. However, there are some extreme distributional changes in the percent of encounter claims by file type.
		LT	There is a higher percent of claims with $0 Medicaid Amount Paid, due to the application of spend down. The file contains mostly weekly bills. The expected percent of claims with patient share payments is lower than expected, but state verifies that it is correct. If the state does not pay for all covered days on claim, the covered days field is not corrected on the claim.
		OT	KS uses some local diagnosis codes. The state system does not carry UB-92 codes on OPD claims, but all OPD claims have service codes.
		RX	There are fewer than expected adjustments in the Q1 file due to system change. These adjustments will be in subsequent quarters.
	Eligibility	CHIP Code	Kansas is not reporting their S-CHIP children. The state does not have an M-CHIP program.
		Dual Eligibility Flag	Some persons in MAS/BOE 41-42 are reported to have restricted benefits related to their dual status (QMB-only, SLMB-only, or "other" dual eligibles). These are potential spend-downers who are incorrectly mapped, as discussed below. Dual Eligibles are somewhat under-counted in Kansas due to a reporting quirk. With correction records, the state is sometimes 0-filling the dual flag for dual eligibles who have died to include the period when they were alive. Kansas uses the dual flag 08 for persons whose income and resources are too high to quality for QMB plus, or SLMB plus, but who still receive full Medicaid benefits.
		Foster Care	Foster care is under-reported in MAS/BOE 48 prior to February 2000 when the number of foster care children almost doubles.

State	File Type	Record Type	Issue
KS	Eligibility	Managed Care	Managed care enrollment patterns changed during FY 1999. To start, from Q1 to Q2, 2 of the 3 HMOs in Kansas withdrew from Medicaid. Then, in April, 1999 (the start of Q3), the remaining HMO changed ownership, meaning that a large group of eligibles had to be reassigned to a new plan ID#. KS officials have acknowledged that they have been overcounting managed care enrollment in MSIS for FY 1999 to FY 2002 data. They are investigating the problem. CMS managed care data are more reliable.
		MAS/BOE	The state believes enrollment was under-counted in FY 2002 Q1-3 due to a problem with the submission of retroactive and correction records. During FY 2002, KS changed how it reported its Work Transition program, so that more eligibles qualified under the 1931 provisions, causing a shift in enrollment from MAS/BOE 44-45 to MAS/BOE From 12/98 through 4/99, Kansas had problems distinguishing between children in MAS/BOE 14 and 34. The state reports that this was related to implementation of their S-SCHIP program (they were trying to make sure children leaving welfare would not be inappropriately terminated from Medicaid). As a result, some children (about 12,000 by 4/99) were mapped to MAS/BOE 34 who should have been mapped to MAS/BOE 14. This problem was corrected effective 5/99. Beginning in April 2000, Kansas changed their nursing home criteria. Rather than using the Medically Needy criteria, the state used the 300 percent institutional rules. As a result, enrollment increased in MAS/BOE 41, 42, and 44 and fell in MAS/BOE 21, 22, and 24. From October 1999 through November 2001, KS reported QMB-only and SLMB-only eligibles who were potential spend-downers to MAS/BOE 31-32. Then, beginning in December 2001, these potential spend-downers were mapped to MAS/BOE 41-42, a mistake. Since potential spend-downers are not considered Medicaid eligibles, these individuals should not have been reported as enrolled in Medicaid with full benefits. Persons in this group are reported in state-specific codes MSSDOA, MSSDAB and MSSDAD. With the implementation of its new system in FY 2004, KS will map potential spend-downers in these groups to MAS/BOE 31-32. Potential spend-downers who do not qualify for restricted Medicaid benefits related to Medicare cost-sharing will not be included in MSIS reporting. During FY 2001 Q2, Kansas took steps to reinstate Medicaid coverage to persons inappropriately terminated during welfare reform. These persons were mapped to MAS/BOE 24/25. This coverage only lasted three months unless persons were otherwise eligible.

State	File Type	Record Type	Issue
KS	Eligibility	Retroactive Records	During FY 2001, Kansas implemented retroactive enrollment to previous quarters for many persons inappropriately terminated during welfare reform.
		TANF/1931	The state reports that they did not correctly implement 1931 rules. There are relatively few non-TANF 1931 eligibles. During FY 2001, the state started to implement changes. Effective FY 2002 Q1, Kansas TANF data are not reliable. The reported number in MSIS is below the number of expected recipients.

State	File Type	Record Type	Issue
KY	Claims	Encounter	The Q199 and Q299 files do not include any encounter data. The Q399 file has a few encounter claim records.
		LT	The state does not pay for leave days.
			The number of covered LT days exceeds the days of enrollment.
		OT	There are no FP claims.
			Less than .5 percent of the claims have a program type of EPSDT. KY reports this is correct and is probably the result of so many children in managed care.
			There are many claims without service codes as state uses UB-92 for HH, hospice, and OPD.
			Dental codes are flagged as state-specific. They can be converted into HPCPS by replacing leading 0 with D
			The Q1 1999-Q2 2002 files do not include individual PCCM capitation claims.
	Eligibility	CHIP Code	KY reported only M-CHIP enrollment in FY 1999. Beginning in FY 2000, the state also reported their S-CHIP data.
			There is a discrepancy between the MCHIP and SCHIP counts in MSIS 2001 data and SEDS 2001 data. The state expects that their MSIS correction records will eliminate this discrepancy.
		Dual Eligibility Flag	Prior to FY 2001 Q4, Kentucky's dual eligibility are incorrect and should not be used. The state was over-reporting the number of disabled and children who were dually eligible.
		HIC Number	Kentucky fixed its dual eligibility flag in FY 2001 Q4. After that time, about 12 percent of the state's non-dual eligibility population have valid HIC numbers.
		Managed Care	Beginning in Q4 of FY 2000, Kentucky phased out the use of Kentucky Health Select (Plan ID 9690005500), a comprehensive managed care plan. The individuals were moved into the state's Medicaid PCCM.
			KY added a new region to its transportation plan in July 2002. However, MSIS reporting did not reflect this new region (about 100,000 enrollees) until October 2002. Then, from December 2002 to April 2003, the state temporarily shut down the transportation plan for this region, before returning services in May 2003.
			By Q499 KY had reported that about one-third of eligibles each month are enrolled in Plan Type 8, which is a special capitation plan for transportation services. By Q402 two thirds of eligibles each month were in the transportation plan, following a sharp increase in July

State	File Type	Record Type	Issue
KY	Eligibility	MAS/BOE	Kentucky exhibits a seam effect from quarter-to-quarter, whereby enrollment declines from the first month in the quarter until the last, and then jumps in the first month of the next quarter. The state submits a significant proportion of retroactive eligibles and correction records, however, which may smooth out enrollment trends.
		SSN	About 4 percent of eligibles don't have valid SSNs.
		Various Fields	In FY 2000, between 200 - 400 persons each month in MAS/BOE 00 have the following fields blank-filled: TANF, Restricted Benefit Flag, Plan Type 1-4, Plan ID 1-4, and CHIP Code.
	Encounter	IP	There is only 1 diagnosis code per claims and no procedure codes.
		OT	There are no claims for waiver services and the service codes are missing on about 9 percent of the claims.
	Encounters	IP	There are no procedure codes on encounter claims.

State	File Type	Record Type	Issue
LA	All	MSIS ID	LA converted to a new eligibility system in mid-1999. Prior to that time, SSNs were not verified and the state used a Medicaid ID numbering scheme that included county and aid code. As a result there is a mis-match between the EL and claims files. LA believes this was corrected in late 1999.
	Claims	Encounter	LA currently doesn't have a managed care program.
		IP	The file does not contain DRGs.
			There are more claims with patient status of still a patient because they generate lots of interim bills due to PA system.
			In the 1999 files Procedure Code 2 has '88' added to the end of the field. LA will fix in future.
			The principal procedure code date is missing.
			There is a large percent of crossover claims. The state verifies that this is correct.
		LT	The diagnosis codes are missing on most claims.
			The admission date is missing on most records.
		OT	Beginning in 2003, the state is paying a fixed rate for FQHC/RHC visits. They will submit claims for line item services with a Medicaid Amount Paid of $0 and a summary claim with the visit rate paid, but no services.
			LA will not longer be able to report Place of Service for HH claims due to HIPAA form changes.
			About 10 percent of the Q199-Q499 claims have a service code flag of 10, but a service code value of "0'.
			There are very few claims with local service codes.
	Claims/EL	SSN	LA is an SSN state, but prior to mid 1999 they did not verify SSN and were internally using a Medicaid ID number that contained county code, EL group, etc. The new EL system checked the accuracy of the SSN. As a result, there are some people in the PSF with more than one MSIS ID and some claims had an MSIS ID not found in the
	Eligibility	CHIP Code	Louisiana plans to expand its CHIP program to cover pregnant women to 200 percent FPL beginning 1/03.
			LA reports its M-CHIP children in MSIS. The state does not have a S-CHIP program. The M-CHIP data differed greatly from the numbers in SEDS until FY 2001, but the state assured us that MSIS data were more reliable. There was a discrepancy between SEDS and MSIS M-CHIP counts, again, in FY 2001 Q4 and FY 2003 Q1. The state insists that it is the MSIS count that is more reliable in this

State	File Type	Record Type	Issue
LA	Eligibility	County Code	From FY1999 to FY 2000 Q1, Louisiana incorrectly used a state-specific county code. This problem was corrected in FY 2000 Q2. The state supplied MPR with a crosswalk, linking together the state and FIPS county codes.
		Dual Eligibility Flag	From FY1999 Q1-FY 2000 Q3, Louisiana's MMIS system does not include the following groups: SLMB, QI1, QI2, QDWI. Beginning in FY 2000Q3, these groups are included in the state's EL file. Only 24-29 percent percent of Louisiana's disabled eligibles are duals -- a somewhat lower than expected proportion.
		Managed Care	Louisiana did not report any managed care enrollment in FY 1999, although the state was running a PCCM plan at this time (enrollment in the plan in June 1999 was approximately 44,000, according to CMS managed care data). Beginning in FY 2000 Q1, the state reported PCCM claims in its OT file for this group, but the state did not begin reporting PCCM enrollment in its EL file until FY 2000 Q2. In the latter half of FY 2002, LA MSIS data shows significant growth in PCCM enrollment. This growth is also reflected in CMS managed care data.
		MAS/BOE	Most poverty-related infants are reported in MAS/BOE 44 instead of MAS/BOE 34, because the state deems these newborns are covered until age 1.
		TANF/1931	Across time, TANF enrollment in MSIS and ACF are diverging. The numbers are very similar in FY 1999, but by FY 2001, the ACF numbers are much smaller than those in MSIS. This problem results from the fact that DHH does not automatically disenroll TANF individuals when notified by DSS. The DHH policy is to extend eligibility for TANF individuals until they are able to determine an appropriate Medicaid disposition. DHH policy requires the individuals to remain in their Aid-Category/Type-Case classification (03/01) for up to 6 months until they can be re-classified. In FY 2003 Q1, ACF and MSIS data on TANF enrollment are very close again.

State	File Type	Record Type	Issue
MA	Claims	Capitation	Capitation payments to plans are made quarterly, not monthly. Even so, there appears to still be somewhat of a shortfall as there are fewer capitation claims than quarterly enrollment in managed care.
			In Q1 1999 Behavioral Health Organization (BHO) capitation claims are flagged as PCCM capitation claims.
			PCCM payments are only made if there is actually a PCCM visit, so there are very few PCCM capitation payments (after Q1 99)
		Encounter	There are no encounter records on the files. Their encounter data need to be submitted for 1115 waiver reporting, and the data have not been made available for MSIS.
		IP	There is a large percentage of crossover claims and very few adjustments - mostly voids.
		LT	There are very few diagnosis codes and no leave days on the files.
		OT	30 percent of the original, non-crossover claims do not have a Place of Service. Most of these claims are outpatient hospital department claims (TOS = '11') or Lab and X-ray claims (TOS = '15')
			The number of HCBS claims vary considerably by quarter, due to the billing and submission cycle.
			Most services to children under age 21 have a Program Type of EPSDT.
			There aren't any FQHC claims.
	Eligibility	1115 Waiver	Massachusetts operates an 1115 waiver program for the disabled, children, and adults.
		CHIP Code	In Q2 FY 2002, persons in state-specific eligibility groups AA01AA, AA01BA, and AA01CA (all mapped to MAS/BOE 44-45) were incorrectly assigned a CHIP code of 2 (M-CHIP) when the code should have been 1 (no CHIP). The state addressed this problem through correction records.
			Massachusetts reports children in both its M-CHIP and S-CHIP programs. The MSIS data are close, but do not exactly track, SEDS data. The state insists that the MSIS data are more reliable.
		Dual Eligibility Flag	From 60-70 percent of the dual eligibles population receives the flag 09, indicating that they are duals, but their dual group (e.g., QMB, SLMB, etc) cannot be determined.

State	File Type	Record Type	Issue
MA	Eligibility	Dual Eligibility Flag	Massachusetts reports very few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL. Also, because Massachusetts provides full Medicaid benefits to all blind/disabled up to 133 percent FPL in its 1115 Waiver program, the state reports very few blind/disabled with dual codes 01 or 03.
		Foster Care	Massachusetts is under-reporting the children in foster care.
		MAS/BOE	The state provides full Medicaid benefits for the aged up to 100 percent FPL and the disabled up to 133 percent FPL.
		Race	More than 20 percent of eligibles are coded with an unknown race.
		Restricted Benefits	25,0000 to 75,000 persons in MAS/BOE 45 are assigned the "other" restricted benefits flag. MPR has requested clarification from the state about this.
		Retroactive Records	Massachusetts decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSI	Enrollment in MAS/BOE 11 is about 2/3 of the SSI aged enrollment reported in SSA administrative data. MPR has requested clarification from the state about this.
		SSN	Massachusetts has roughly 1,000 SSNs assigned to more than one record. The state reduced this problem in FY 2002 Q4 to <500.
		TANF/1931	The number of monthly TANF recipients reported in MSIS is considerably higher than ACF administrative data on TANF for the same period.

State	File Type	Record Type	Issue
MD	Claims	All	Nearly two-thirds of the Medicaid recipients are enrolled in the HealthChoice Program. The remaining one-third tend to be either sicker (many institutionalized)or covered by Medicare. As a result, the distribution of Maryland's FFS claims may seem quite different from the distribution for other states.
		Encounter	There are very few IP or LT encounter records. Most of the encounter records are in the OT file (73 percent of encounter claims) or the RX file (27 percent)
		IP	A higher than expected percentage of original, non-crossover FFS claims have a Patient Status of '30': Still Patient because the IP file contains Chronic and Rehab in addition to acute hospitals. Maryland does not use DRGs (there are no DRGs on the IP file). The State reimburses in state acute general hospitals using a percent of charges for rates established by the Health Services Cost Review Commission (HSCRC) under a Medicare waiver. Out of state hospitals are reimbursed according to that state Medicaid Programs reimbursement principles. Other hospitals in the state are reimbursed on a per diem basis and many are subject to cost settlement. A higher than expected percentage of original, non-crossover FFS claims do not have ancillary codes. This higher percentage is due to a higher percentage of per diem hospitals that remain for the sicker population. These hospitals only receive a room and board charge. Because nearly two-thirds of Medicaid recipients are enrolled in managed care, the fee-for-service hospital costs tend to be higher than for other states with less Medicaid managed care. See above comment about types of enrollees included in FFS.
		LT	No one has a patient status code of 'died'. MD does not report leave days. In Q3 1999, there is a sharp increase in the number of child IP psych claims. In addition, there was an increase in the number of OT claims. The state notes: "During this time period the Administrative Services Organization that processes and pays Specialty Mental Health Services claims was in the process of cleaning up claims that they had previously paid but that were needed to be processed through MMIS for federal claiming. As part of our 1115 Waiver, Specialty Mental Health Services (SMHS) were transferred to the Mental Hygiene Administration to develop a unified SMHS for all Medicaid and grey area recipients. SMHS were carved out from the MCO's responsibility. The ASO encountered some initial start-up issues that delayed the submission of paid claims to MMIS. During the federal third quarter there was a significant push."

State	File Type	Record Type	Issue
MD	Claims	LT	The Admission Date is not a required field on continuing stays. As a result, the Admission date is missing on 18 percent of the original, non-crossover FFS claims. Most LT claims do not have diagnosis codes.
		OT	There was an increase of almost 1 million claims in the 1999 Q2 file over the number of claims in the Q1 OT file. This was the result of another agency sending in a large batch of old mental health claims in Q2. Most of these claims have a TOS of Rehab. The distribution of claims, by Type of Service, is unusual due to the high percentage of individuals enrolled in managed care. Most of the original, non-crossover FFS claims are for Home Health, Physical/Occupational Therapy or Rehabilitation. 25 percent of the original, non-crossover FFS claims in Q1 1999 do not have a Place of Service. There was a large increase in the number of OPD claims in Q4 1999.
		RX	There are no Family Planning claims.
	Eligibility	CHIP Code	Maryland reports its M-CHIP eligibles, however until FY 2001 Q3 M-CHIP children in state groups P11 and P13 were not counted. This problem was fixed using correction/update records. In Q4 FY 2001 the state began to identify its S-CHIP children (in state groups DO1, DO2, DO3, and DO4).
		County Code	Maryland reports eligibles with County Code = 510. These are residents of the city of Baltimore. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "007."
		HIC Number	Almost 27,000 non-duals have HIC numbers (about 6 percent of the non-dual population).
		Managed Care	Some persons have the PLAN ID field 9-filled.
		MAS/BOE	During the second and third months of FY 2000 Q1, enrollment jumps by over 50,000 in MAS/BOE 22. The state reinstated these eligibles after improperly terminating their Medicaid benefits. They are mapped to an incorrect MAS/BOE group, however, and the state used correction/update records in FY 2000Q4 to resolve the problem. Maryland reports more SSI recipients (MAS/BOE 11 and 12) each month than expected, based on a comparison to federal SSI administrative data. However, the state administers a SSI supplement program.
		Restricted Benefits	Many of the poverty-related women in MAS/BOE 35 only qualify for restricted benefits (Code 5) related to family planning.

State	File Type	Record Type	Issue
MD	Eligibility	SSN	More than 23,000 persons have the SSN field 9-filled (4-5 percent of the population).

State	File Type	Record Type	Issue
ME	Claims	Adjustments	There are very few adjustment claims on the files. Maine has indicated that the number of adjustment claims is accurate.
		Encounter	There are encounter claims on the OT file.
			Although there were OT encounter records for service dates in 1999, the numbers of such records have fallen off drastically so that by 2001 Q1 there are only 5 such records.
		IP	In Q2 1999 the admission date is mostly missing.
			There aren't any DRGs.
			Approximately 10 percent of the original, non-crossover FFS claims do not have an accommodation code. This percentage is higher than expected. However, because Maine prepays hospitals, the Revenue code is not used to reimburse hospitals, and therefore it would not be unusual to have a higher percentage of claims without accommodation codes than expected.
			ME stopped paying Medicare coinsurance/deductibles as part of an agreement with the hospital association, so there are very few crossover claims in the IP file.
		LT	In each file in Q1-4 99 there are a few NF claims, that have the NF covered days correctly coded, but also a large negative value in the ICF/MR covered days field. If this field is used to calculate averages or rates, it will result in a large negative value. ME is investigating and plans to fix in future submissions.
			The state doesn't report leave days.
		OT	Maine creates a summary bill on outpatient department claims with separate line items. Each line item should be included as a separate claim without the TPL, and then an additional claim should be included that has only the TPL amount. The TPL amount would be a negative dollar value matching the positive value in the Other Third Party Payment field. As a result, there are original and resubmittal claims with a negative Medicaid Amount Paid.
			The percentage of original, non-crossover FFS transportation claims is higher than expected.
			ME discontinued its 1 HMO around the beginning of 2001.
		RX	There are no adjustment claims on the file. Maine has indicated that this is OK, because drug claims are Point of Service.
	Eligibility	CHIP Code	Maine has both M-CHIP (state code 3P) and S-CHIP (state code 000000) programs, and both are reported into MSIS.

State	File Type	Record Type	Issue
ME	Eligibility	County Code	In Q3 FY 2001, the number of enrollees with county code 999 increased to 13,000 (from 1,000 in Q2), presumably caused by enrollees in the new prescription drug program.
		Date of Death	Dates of death are 8-filled for all eligibles.
		Dual Elig.	Maine extends full Medicaid benefits to the aged and disabled with income <100 percent FPL, accounting for the somewhat lower than expected proportion of QMB-only dual eligibles. In Q1 FY 2001, enrollment declined in QMB-only (Code 1) and increased by about the same number in Qualified Individual (Code 6). Many of the enrollees in the new prescription drug program in Q3 FY 2001 were assigned dual code 00 and 08.
		HIC Number	Only 91-93 percent of dual eligibles had a valid HIC number. This proportion dropped to 69 percent with the implementation of the new prescription drug program in Q3 FY 2001 and continued to decline in FY 2002.
		Managed Care	During FY 2000, comprehensive managed care declined and PCCM enrollment increased. This shift happened as the state phased out its managed care contract with Aetna and increased its PCCM enrollment. From March to April FY 2002, the number of persons reported to have private health insurance fell from 30,000 to 21,000. The state
		MAS/BOE	During FY 2001, child enrollment shifted between MAS/BOE 34 and 44 in January. Adult enrollment shifted between 45 and 15 in July, 2001, when ME expanded its section 1931 eligibility provisions to include parents with income to 150 percent FPL (group 4Y). In FY 2002, state group 53 began to be reported, but was mismapped to MAS/BOE 21, instead of MAS/BOE 22. In June 2001, the state launched a Medicaid prescription drug program for the aged and disabled under an 1115 waiver. This program was shut down as a result of a court ruling in December 2002. In the six months prior to the waiver's start, about 1500 persons were mapped to MAS/BOE 51-52 due to programming complexities. They should have been mapped to MAS/BOE 31-32. In October 2002, a new 1115 waiver extended Medicaid to childless adults under 100 percent FPL. The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.

State	File Type	Record Type	Issue
ME	Eligibility	MAS/BOE	Throughout FY1999 and FY 2000, Maine had an age-sort problem in MAS/BOE 44 and 45. There were also age sort problems in MAS/BOE 24-25 in FY1999. Only persons older than age 20 should have been mapped to MAS/BOE 45 (or 25). Persons under age 21 should have been mapped to MAS/BOE 44 (or 24). In September 2000, the state implemented a new program to cover the parents of CHIP eligibles from 100-150 percent FPL. The state tried to get a waiver through to make these adults eligible for the higher CHIP matching rate, but were unsuccessful. Each month in FY1999 and FY 2000, roughly 4-5 percent of the persons in BOE 1 are younger than 65. This is a higher-than-expected proportion. Additionally, in BOE 4 each month, roughly 7 percent of the enrollees are older than age 20. This, too, is a higher-than-expected proportion.
		Restricted Benefits Flag	In some quarters, not all the persons assigned dual codes 01 and 03 were assigned restricted benefits flag 3. Aged and disabled persons enrolled in the 1115 prescription drug program (MAS/BOE 51-52) should have been assigned restricted benefits code 5, instead of restricted benefits code 1 (full benefits). The state will correct this problem beginning in FY 2003.
		Retroactive Records	Maine decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		TANF/1931	Maine's TANF numbers are consistently higher than ACF numbers. The state believes MSIS is overcounting TANF enrollees.
	Eligibilty	MAS/BOE	In FY 2000 Q2, the state began to separate out the unemployed adults and their children. They had previously been enrolled in MAS/BOE 14-15, but are now reported separately into MAS/BOE 16-17.

State	File Type	Record Type	Issue
MI	Claims	Capitation	The BHO capitation claims are reported as service tracking claims in the 1999-2002 OT files. The state started submitting them Q1 2003.
		Encounter	MI expected to start submitting encounter claims in FFY 2001, but as of Q1 2002, no encounters are being sent.
			The state will not be able to assign the Type of Service for many claims because the plans are not often submitting the information needed for TOS classification. They also use the plan specific provider types, making it impossible for the state to identify the type of provider. The claims have some non-specific types of service like 'critical care'.
			The state can't distinguish between FQHC and RHC claims in their managed care data.
		IP	The number of claims decreased from 1999 Q1 to Q4
		OT	There was a sudden shift from state to HCPCS codes between Q3 and Q4 2001.
			The average Medicaid amount paid differed considerably across Qs for phys, clinic, abortions, total services
			Place of Service of ER is not reported until Q4 2001.
			Only about 80 percent of claims have a service code. This may be due primarily to OPD claims billing on a UB-92. The OPD claims do not have either a service code or revenue code.
			There are not any service codes or UB-92 revenue codes on OPD claims.
		TPL	The other third party liability is missing on all claims.
	Eligibility	CHIP Code	Beginning in Q2 FY 2002, the state changed its SEDS reporting to accurately report enrollees that have aged out of the M-CHIP group. However, MSIS data do not yet reflect this change. Thus, there is an overcount of M-CHIP eligibles beginning in Q2 FY 2002.
			Michigan reports its M-CHIP enrollment. It does not report its S-CHIP enrollment, however.
		Date of Death	All dates of death are "8-filled".
		Dual Eligibility Flag	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
			Roughly half of Michigan's dual eligible population (approximately 90,000 eligibles) are reported with dual code 09 each quarter. Also, Michigan reports few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL.

State	File Type	Record Type	Issue
MI	Eligibility	Managed Care	Michigan reports PCCM enrollment in FY 1999 Q1-2, but enrollment phases out in FY 1999 Q3. Beginning in FY 2000 Q3, the state reports enrollment in a dental managed care plan. Dental plan enrollment is not included in the CMS managed care report for Michigan. In each quarter, a few Plan IDs are used that do not appear in the crosswalk. In addition, many Plan IDs are 10 bytes long, with 3 leading zeroes, while others are 7 bytes long with no leading zeroes. Michigan underreported enrollees in its BHP managed care plans in FY1999. This problem was corrected in FY 2000 files.
		MAS/BOE	Michigan has a higher than expected number of enrollees younger than age 16 in BOE 5. This is likely tied to the fact that the state maps its state-specific eligibility groups directly to MAS/BOE groups, rather than using any sort of age sort. Until FY 2003, SLMB-only and QI 1&2 eligibles older than 65 in state codes M2H and M2J were erroneously mapped to MAS/BOE 32. They should have been mapped to MAS/BOE 31. This problem was corrected in FY 2003.
		Race Code	The number of eligibles with "unknown" race codes varies between 2 and 6 percent.
		TANF/1931	Michigan is unable to provide TANF flags for its Medicaid population. All eligibles receive a TANF flag of 9, indicating their TANF status is unknown.
	Encounter	All	Most encounter claims have the regular encrypted Medicaid ID for the MSIS ID, but Judy Moran thought that some claims were coming in with the SSN. However, she believes that these SSNs are being crosswalked to the MSIS ID. Need to check when we start receiving encounter data. They are submitting line item claims and often each line has the same diagnosis code. MI thought that the diagnosis code probably applied to all lines, but were concerned that if there were, for example, 11 line items for an abortion all with an abortion diagnosis, it would be counted as 11 abortions.
		OT	The MI encounter contractor lumps FQHC and RHC claims into one code so it currently isn't possible to properly code Program Type. Those claims will be reported with an unknown Program Type. The billing provider ID is not always included on encounter claims and the servicing provider ID may be the provider tax ID or the provider ID assigned by the plan.
	Encounters	IP	The procedure code is missing on 95 percent of the claims.

State	File Type	Record Type	Issue
MI	Encounters	LT	75 percent of the claims have only one covered day.
			The only type of service is NF.
			Patient status is missing on most claims.
		RX	The fill date is always missing. Possibly the prescribed date can be used.

State	File Type	Record Type	Issue
MN	Claims	Encounter	The number of encounter claims increased from 1 to 10 million between Q3 and Q4 1999.
		IP	There aren't any family planning claims. The state said none meet the definition. The professional component is billed in the OT file.
		IP/LT	Starting in Q3 2001 MN moved their chemical dependency claims from IP to LT.
		LT	The diagnosis code is '00000' on most claims.
			The ICF/MR days are missing on many ICF/MR claims.
			The percent of ICF/MR claims is greater than expected.
		OT	The percent of lab claims is lower than expected.
			The provider specialty code is missing on most claims.
			The distribution of claims paid each month is uneven.
		RX	The date prescribed missing.
			The distribution of claims paid each month is uneven.
	Eligibility	CHIP Code	Minnesota has a very small M-CHIP program that covers only infants with income from 275 - 280 percent FPL.
			Minnesota is reporting its M-CHIP children. The state did not have an S-CHIP program until Q4 FY 2001, when it transferred adults from its 1115 waiver to S-CHIP. Then S-CHIP enrollees are included in MSIS under MAS/BOE 00.
			SEDS data in FY 2002 are not reliable.
		Managed Care	The number of enrollees with state-purchased health insurance declined from 8,000 in Q4 FY 2000 to 5,600 in Q1 FY 2001. The drop was the result of MN's deletion of a number of records that had been found to be erroneous.

State	File Type	Record Type	Issue
MN	Eligibility	MAS/BOE	In July 2001, MN exercised the OBRA 86 option, extending full Medicaid benefits to the aged and disabled to 95 percent FPL. However, these individuals were not assigned a special eligibility code and will not be identified in MSIS data until Q3 FY 2003. They are probably reported to MAS/BOE 41-42. In addition, in FY 2001, MN began extending "access" services to aged persons whose eligibility was not yet finally established. In FY 1999 and FY 2000, the assignment of enrollees to MAS 2, 3, and 4 was not reliable in Minnesota, except to the extent that individuals were identified as aged, disabled, children, or adults. As an example, "children" at a general level were appropriately identified, but the sorting of children by medically needy, poverty-related, or other status had many errors. Only the MAS/BOE 11-15, 48, and 54-55 designations are reliable. Until FY 2001, the state had an MSIS coding mistake related to income -- and income is a critical variable to the assignment of individuals across MAS 2, 3, and 4. Researchers should not use the MAS 2, 3, and 4 designations prior to FY 2001, except to identify the individuals as aged, disabled, children, or adults. With the FY 2001 data, the problems are fixed. Effective FY 2001, Minnesota reports almost all of its poverty-related children and adults into MAS/BOE 54 and 55 as a part of its MinnesotaCare 1115 Waiver Program. About 24,000 adults transferred out of MAS/BOE 55 to the S-CHIP parent program in Q401.
		Restricted Benefits	Persons assigned restricted benefits code 5 only qualify for "access" services, since their eligibility has not yet been fully established.
		TANF/1931	In FY 1999 and FY 2000, 99 percent of children and adults in MAS/BOE 14-15 are TANF recipients. In Q1 FY 2001, the TANF numbers in MSIS were 15 percent higher than the TANF administrative data. This discrepancy increased to 45 percent in Q1 FY 2002. Eligibles reported as TANF recipients in Minnesota's data are actually recipients of the Minnesota Family Income Program. For their Medicaid population, this is nearly equivalent of the TANF code and is of greater interest to the state (from a data feedback perspective).

State	File Type	Record Type	Issue
MO	Claims	Encounter	In 2003 about 3 percent of the IP encounter claims have an invalid type of service .
			There are some encounter claims in the OT, LT and IP files, but don't appear to be complete
		IP	One of most frequent diagnosis code - Y85 - is not an ICD-9 code
			DRG not on file
			Higher than expected percent still a patient.
		LT	The admission date is missing
		OT	33 percent of claims have service type 19. The states says those are mostly claims for homemaker chores
			There aren't any claims with a type of service of sterilization or abortion.
			Only two percent of claims are for lab/X-ray. The state reports all appropriate lab/Xray claims moved to OT
			There aren't any claims for several types of service.
			The Servicing ID is mostly missing
			OPD claims have service codes rather than UB-92 revenue codes.
		RX	All compound drugs are coded as COMPOUND in the NDC field
			The Date Prescribed is missing
			The new refill indicator is missing
	Eligibility	CHIP Code	Missouri is reporting M-CHIP eligibles into MSIS. The state does not have an S-CHIP program. The data differs from SEDS through FY 2001, but the state insists their MSIS data are correct.
		County Code	Missouri reports eligibles with County Code = 510. These are residents of the city of St. Louis. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "191."
		Dual Eligibility Flag	According to the state, these are eligibles that might qualify under QMB or SLMB rules, but pay for their own Part B premiums as a part of their spend down. The state also indicated that dual eligibles have to apply for QMB/SLMB coverage.
			MO differs from most other states in its dual eligibles policies. About 45 percent of the total dual population (61,000 persons) are assigned dual code 08.

State	File Type	Record Type	Issue
MO	Eligibility	Health Insurance	In Missouri's Q1 FY 1999 file, roughly 5,000 persons who were ineligible for Medicaid during the month (i.e., those in MAS/BOE 00) received HEALTH INSURANCE flags, indicating that they were eligible for Medicaid during the month. This problem was corrected in Q2.
		Managed Care	Missouri was under-counting managed care enrollment in FY1999. This problem was corrected in FY 2000.
		MAS/BOE	Enrollment in MAS/BOE 14-15 jumps by roughly 40,000 persons in July 2000. This shift is caused by the reinstatement of persons who lost Medicaid because their welfare benefits were terminated. This special initiative ended in March 2001. Effective Q2 FY 2002, MO increased its 1931 income threshold to 100 percent FPL, causing many children to transfer from MAS/BOE 34 to 14 and many adults to transfer from MAS/BOE 55 to 15. Effective Q4 FY 2002, the 1931 threshold was lowered to 77 percent FPL, causing many adults to disenroll and some children to transfer from MAS/BOE 14 to MAS/BOE 34. Also, in Q4 FY 2002, MO cut back eligibility for 1115 enrollees in MAS/BOE 55, reducing TMA coverage for sate groups 76C and 80R from 24 months to 12 months. In FY 2002 Q3-4, approximately 2,000 enrollees in state-specific eligibility group 11M (Medical Assistance -- Old Age assistance) were falsely reported to MAS/BOE 41 rather than MAS/BOE 11 and about 4,500 enrollees of group 13M (Medical Assistance -- Aid to Disabled) were falsely reported to MAS/BOE 42 rather than MAS/BOE 12. This error was resolved by FY 2003 Q1 and FY 2002 Q3-4 were fixed through correction records. Missouri reports a larger than expected number of persons younger than age 65 in BOE 1. Eligibles in state-specific eligibility groups AALN00, BBLN00, and CCLN00 are mapped only to MAS/BOE 31. Eligibles in these groups that are younger than 65 should be mapped to MAS/BOE 32. The state corrected this in FY 2002 Q3. MO is a so-called 209(b) state. This explains why the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by Social Security Administration. Effective Q2 FY 1999, Missouri extended full Medicaid benefits to adults in its 1115 program (MAS/BOE 55). In addition, some adults in MAS/BOE 55 only qualify for family planning benefits. Children were already covered. Missouri does not provide medically needy coverage.

State	File Type	Record Type	Issue
MO	Eligibility	Restricted Benefits	Some presumptively eligible pregnant women in MAS/BOE 34 (state code 58PL00) are assigned restricted benefits code 4 (pregnancy related). In addition, adults in state code 80R000 (mapped to MAS/BOE 55) only qualify for family planning benefits; however, they are not assigned a restricted benefits code. The state has been asked to fix this in the future.
	Encounter	IP	In 2002, only 30 percent of the claims had ancillary codes, and 13 percent have procedures.

State	File Type	Record Type	Issue
MS	Claims	Capitation	The MS HMO program ended 10/99, however, there are some lagged capitation claims and around 8,000 HMO enrollees listed in the Q1 and Q2 2000 EL files.
			The HMO capitation void claims in Q1-3 99 appear to be lump sum adjustments.
		Encounter	In FY 1999, there are encounter claims on the IP, OT, and RX files.
		IP	The IP file has a high number of adjustment claims in Q1. The State has confirmed that this is accurate.
			There aren't any claims with a Program Type of Family Planning.
		LT	There aren't any claims with a service type of 02 - MH for Aged as this is not covered in the state plan.
			The percent of claims with an unknown patient status increased from 0 percent in Q1/2 1999 to 34 percent in Q4 1999.
		OT	The state has put revenue codes into the service code field on about 25,000 original non-crossover claims in Q1 1999.
			There are no PCCM claims in the 1999 files. The state starting including these claims in the FFY 2000 files.
	Eligibility	CHIP Code	Effective 1998, MS had both an M-CHIP and an S-CHIP program. The M-CHIP program phased out in FY 2002. The S-SCHIP program is not reported in MSIS.
			Mississippi's state-specific eligibility group "91" encompasses M-CHIP children, non-CHIP poverty-related children and poverty-related pregnant women. The state cannot accurately determine which individuals in state group "91" are M-CHIP children, however. Thus, Mississippi elected to assign CHIP code "9" (CHIP status unknown) to all individuals under age 19 in "91." The state erroneously continued this practice in FY 2003 Q1-3 after the M-CHIP program had been discontinued. These individuals should have been assigned CHIP code 1 ("eligible and no chip") after the
		Dual Eligibility Flag	Beginning in Q4 FY 2000, Mississippi extended full Medicaid benefits to eligibles up to 135 percent FPL. As a result of this change, the number of SLMB-only dual eligibles dropped from more than 8,000 in Q3 to around 1,000 in Q4.
			Mississippi provided full Medicaid benefits to eligibles up to 100 percent FPL through Q3 FY 2000. As a result, the state reported very few QMB onlies (DUAL ELIGIBILITY FLAG = 01).
		Foster Care	Mississippi reports a smaller proportion of children in foster care than we generally expect.
		Managed Care	The PCCM program was discontinued April 2002.

State	File Type	Record Type	Issue
MS	Eligibility	Managed Care	Beginning in November 1999, Mississippi stopped reporting any eligibles with comprehensive managed care.
		MAS/BOE	Through FY 2000 Q3, the state provided full Medicaid benefits for the aged and disabled up to 100 percent FPL. In FY 2000 Q4, the state began to provide full Medicaid benefits up to 135 percent FPL for this population. Beginning June 2001, Mississippi changed its reporting system as part of the welfare delinking process so that now state group 85 includes 1931 eligibles AND TMA enrollees. As a result, TMA enrollees were no longer separately identifiable and no longer reported to MAS/BOE 44-45. They are now mapped to MAS/BOE 14-15. Only a small group of hospice recipients remain in MAS/BOE 45 in FY 2001. No one is assigned to MAS/BOE 45 in FY 2002.
		Private Health Insurance	In April '03, MS reported a surge in private health insurance of about 4,000 (16 percent). The state believes they had been under-reporting private health insurance enrollment prior to this time.
		SSN	Roughly 5 percent of Mississippi's eligibles did not have SSNs. Many of these eligibles have been identified as "K Babies" (state-specific eligibility group "KK"). These eligibles are newborns who have yet to receive SSNs.
		TANF	In Q1 FY 2002, the number of TANF recipients was about 20 percent less than the number reported in ACF administrative data. Data from the two sources began to converge in Q2 and the discrepancy was within the expected range by Q3; however, in FY 2003 discrepancies reappeared.

State	File Type	Record Type	Issue
MT	Claims	Encounter	There are some encounter records on the IP, LT, and OT files.
		IP	There are no claims with a Program Type of Family Planning. According to the state, "The Montana MMIS does not specifically mark claims as family planning based on the face of the claim. Therefore, we derive this from the family planning indicator on the diagnosis code. This is not a complete method, however, we do not have anything more accurate."
			The DRGs appear to be HCFA DRGs, but they are state-specific. According to the state, "We initially believed that "MT" was appropriate because we expand the 3 digit HCFA grouper into a 5 digit version for Montana to indicate patient age and facility size. Our concern is that the HG followed by the 5 digit DRG will result in another data validity edit."
			The percent of claims with a patient status of 'still a patient' increased to 7.5 percent in Q4 2000.
			There weren't any claims paid in Month 3, Q3 FFY 2000, but there wasn't a drop in the claim count for the quarter, so it doesn't appear that the state failed to submit a month's worth of claims.
		LT	There weren't any claims with a patient status of died.
			1999-2001 files: Patient Status is not available on most claims even though it was submitted on 1998 MSIS files. Montana claims that only a few facilities ever report anything in the field, and that when something is reported it is almost always "unknown."
			There are no crossover claims on the file. The state does not process long term facility claims as crossovers.
			There are no claims with a Type of Service of '02' (Aged Mental Health Hospital) or '04' (Child Inpatient Psych.) in the Q1-3 1999
			1999-2001 files: State reports that mental health services are entirely state-funded and therefore not included in MSIS.
			On all original claims, the Other Third Party Payment amount is almost always $0. This is OK according to the state, who notes that "The Nursing Home TAD claim form does not contain a field specifically for TPL (third party liability). This amount has been included in the personal resource amount."
		OT	There is a significant shortfall of PCCM capitation claims
			There are some debit adjustment claims with a negative Medicaid Amount Paid
			The percent of lab claims is lower than expected.

State	File Type	Record Type	Issue
MT	Claims	OT	Some original, non-crossover FFS claims have a negative Medicaid Amount Paid. This is OK because the state needed to create dummy bills in cases where they had summary bills. On the summary bills, the state assigned the allowed amount on each line item into the Medicaid Amount Paid field, and then created a dummy claim which had cost sharing. The cost sharing (e.g., copayments, TPL) was included as a negative amount paid on the dummy record. Previously, Montana's files had 40 percent of the claims with a zero Medicaid Amount Paid. This solution was developed by MPR.
	Eligibility	Age Sort	Montana had an age calculation problem until Q3 FY 2002. In Q1-2 FY 2002, 3-4 percent of enrollees in BOE 4 were over age 20.
		CHIP Code	Montana begins reporting its S-CHIP data in FY 2000. There was a considerable discrepancy between SEDS and MSIS S-SCHIP counts in FY 2002 Q3. According to the state, the SEDS numbers are incorrect. Subsequent SEDS data is comparable to MSIS data.
		Dual Eligibility Flag	Dual eligibility groups QDWI, QI1, and QI2 are not included on Montana's MSIS files.
		Managed Care	Enrollees with restricted benefits are assigned "88" (not applicable) in Plan Type 1 and "07" (PCCM) in Plan Type 2. MSIS and CMS data are generally consistent on managed care enrollment in HMOs and PCCMs. However, the June 1999 CMS data show 70,000 persons in PHPs. According to state officials, this was an error. No PHP enrollment is shown in MSIS.
		Restricted Benefits Flag	Montana's welfare reform program, called "FAIM," extends reduced Medicaid benefits to some adult eligibles.
		TANF/1931	Montana cannot identify TANF recipients. All eligibles are coded with TANF = 9, indicating that TANF status is unknown.

State	File Type	Record Type	Issue
NC	Claims	Adjustments	There are fewer than expected adjustment claims because many adjustments are done as cost settlements and not as adjustments to individual claims.
		Encounter	The OT and IP files contain a very small number of encounter claims. The LT and RX files have none.
		IP	The procedure code field sometimes contains '8888' instead of
			Some claims have procedure dates after the date of the file because this field is not validated by the state MMIS system.
			Some HCFA DRGs were recoded to state defined codes (801-805,810).
		LT	A slightly higher than expected percent of claims are for ICF/MR services which the state has confirmed is correct.
		OT	The place of service is missing or has invalid codes on most claims in 1999. The percent with valid codes has increased somewhat over time. About 60 percent of the OT claims have valid codes in the 2002 files.
			There are a few adjustment claims with the incorrect sign.
			All claims with service codes have a Service Code Indicator of 6 (HCPCS), but about 40 percent of the codes are CPT-4 and should have in indicator of 1. The state has been asked to correct this in their next submission.
		RX	The prescribing physician ID is missing.
			The file contains non-standard NDC codes that start with "0A" in
	Eligibility	CHIP Code	NC has opted to report its S-CHIP group. The state does not have an M-CHIP program.
		Correction Records	Analysis of NC correction records in the Q1 FY 2003 file for Q4 FY 2002 indicated that 60 percent of the records did not change any key data elements. The records with changes seemed appropriate.
		Dual Eligibility Flag	Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled, up to 100 percent FPL. This is reflected in changing dual flags and restricted benefits for persons in MAS/BOE 31 and 32 beginning in 1999 Q2. This also caused some enrollment to shift from MAS/BOE 21/22 to 31/32.
			About 11 percent of persons age 65 and older are not reported to be dually eligible for Medicare in 1999 Q1 a somewhat higher proportion than expected. This issue was corrected in subsequent quarters.

State	File Type	Record Type	Issue
NC	Eligibility	Managed Care	In October 2001, the Wellness Plan of NC was terminated, causing a noticeable drop in HMO enrollment. In December 2002, United Health Care was terminated, also causing an enrollment drop. North Carolina was reporting its 1915b health plan (CALTERN) as a comprehensive managed care plan (Plan Type 01), while it was reported as a PHP in the CMS managed care system. Enrollment in the plan expired at the end of June 1999.
		MAS/BOE	Enrollment in several of the MAS/BOE groups shows a seam pattern each quarter, with enrollment highest in Month 1 and lowest in Month 3, but increasing in Month 1 of the next quarter. This may be smoothed out over time by retroactive and correction records. Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled to 100 percent FPL. This caused some enrollment shifts from MAS/BOE 21/22 to 31/32. Roughly 2,000 eligibles were mapped to MAS/BOE 46 and 47 each month in 1999 Q1. These persons should have been mapped to MAS/BOE 44 and 45. In the remaining quarters of FY 1999, this number was down to a few hundred per month. By the end of FY 2000 Q1, this problem disappeared. Effective 11/1/99, North Carolina expanded their 1931 eligibility rules to cover eligibility for 12 months after termination of TANF benefits. These enrollees would otherwise have received transitional Medicaid (MAS/BOE 44-45). As a result, enrollment increased in MAS/BOE 14-15 in FY 2000, while it fell in MAS/BOE 44-45. Beginning in FY 2001 Q1, North Carolina reinstated a large group of former AFDC welfare enrollees in to MAS/BOE 14-15. These enrollees may have been inappropriately terminated from Medicaid as a result of welfare reform. At the peak in April 2001, this reinstated group more than 70,000 persons. By October 2001, it had dropped to about 10,500, according to the data provided by the state. This policy accounts for the increase in MAS/BOE enrollment in FY 2001. Effective 11/1/99, North Carolina eliminated their UP Policy. After that date, no eligibles are reported into MAS/BOE 16 or 17. About 700 refugees were mapped to MAS/BOE "**" each month in FY 1999 Q1.
		Restricted Benefits Flag	The women in MAS/BOE 35 who receive RBF = 2 (restricted benefits on the basis of alien status) are aliens who receive coverage for emergency services, including labor and delivery.
		TANF	In FY 2000 through FY 2002, TANF counts in MSIS were 13-14 percent higher than ACF TANF counts. In FY 2003, MSIS counts were 19 percent higher.

State	File Type	Record Type	Issue
ND	Claims	Capitation	There are very few HMO capitation claims until Q1 2000.
		Encounter	There are some IP and OT encounter claims. There are very few IP encounter claims (only 79 claims).
		IP	About 6 percent of the claims do not have ancillary codes. This is because MH and rehabilitation claims are billed using the comprehensive UB-92 code that includes accommodations and ancillary services.
		LT	Nearly all of the claims do not have diagnosis codes.
	Eligibility	CHIP Code	North Dakota reports its M-CHIP children. The state has an S-CHIP program, but did not start reporting those children in the file until 10-99.
		Correction Records	The number of correction records increased in FY 2001 Q2 due to changes in the state's reporting system. There will also be a high volume of correction records in Q3, as the state changes the way that it reports the "days of eligibility" data element in order to comply with CMS standards. This change will not effect the value of any data elements, just the way that it is reported.
		Dual Eligibility Flag	Most dual eligibles receive the dual flag 09, since North Dakota cannot correctly identify the dual groups to which they belong.
		Health Insurance	North Dakota reports that about 18 percent of its eligibles have private insurance, a higher than expected proportion.
		Managed Care	The provider ID of the state's only HMO (Altru Health Plan) changed from "0006900" to "MCO" in FY 2002.
		MAS/BOE	Because North Dakota is a 209(b) state, they report a somewhat lower proportion of SSI recipients in MAS/BOE 11 and 12 than usually expected. In Q4 FY 2001, ND made changes to its 1931 policies that resulted in increased enrollment in MAS/BOE 14-17, with declines in other child/adult groups.
		Retroactive Records	Each quarter, a sizable proportion of retroactive and correction records are for 6+ months ago, a somewhat unusual pattern.
		TANF	ND reports fewer enrollees in MAS/BOE 14-15 than are reported to be TANF recipients in ACF data (state officials cannot explain why counts differ).

State	File Type	Record Type	Issue
NE	Claims	Capitation	In Q4 99 the average amount paid for HMO capitation claims doubled as the state consolidated multiple payments being made to the same HMOs for different services.
		Encounter	From the State: "At this point in time, our encounter data are not useable. We do not have the resources to create an MSIS tape that we know will have to be replaced. After working with the managed care plans on data quality issues and reconfiguring (when possible) the data we have received, it is possible that we will have encounter data ready for MSIS in early 2001. As with the non-MMIS records, when the encounter data are available, we will be able to create historical as well as current records."
		OT	In the 1999 and 2000 files, NE will include a lump sum claim in each quarter for their waiver, transportation, and targeted case management claims. Most of these claims are processed outside of Nebraska's MMIS, and the State has indicated that it will not be able to create line item claims. The State notes that when their methodology for creating line item claims is complete, they will be able to create historical records.
		RX	The following data elements are not available: Days Supply, Date Prescribed, and New Refill Indicator.
		Waiver Claims	The 1999-2004 OT files include some of the waiver services as individual claims and some as service tracking. The percent varies across quarters with a drop in Q1 2003. The state is working on changing their system so they can report all waiver services as individual claims.
	Eligibility	CHIP Code	Nebraska's MSIS data include their M-CHIP enrollees (the state does not have an S-CHIP program).
		DOB	See Unborn Child note.
		Dual Eligibility Flag	Nebraska does not report any eligibles with the dual code 01, since the state extends full Medicaid to all aged/disabled <100 percent FPL. In Q1 FY 2002, SLMB-only dual eligibles were mistakenly excluded from MSIS. This resulted in a dip in MAS/BOE 31-32 that rebounded Only 80 percent of eligibles in MAS/BOE 11 (Aged-cash) are reported as dually eligible. This is lower than generally expected, but the overall dual rate for BOE 1 is 95 percent.

State	File Type	Record Type	Issue
NE	Eligibility	Managed Care	There was no behavioral managed care reported in MSIS in Q4 FY 2002. The state failed to report this enrollment as NE moved from the Value Options BHP plan to the Magellan plan. BHP reporting was returned to the data in FY 2003 Q1 and the state fixed FY 2002 Q4 through correction records. NE did not enter a PCCM plan ID through Q3 FY 2003.
		MAS/BOE	Nebraska requires SSI recipients to separately apply for Medicaid, accounting for the somewhat lower-than-expected count in MAS/BOE 11 and 12. In FY 2000 Q4, Nebraska begins to correctly re-map eligibles who had been mapped to MAS/BOE 99 in previous quarters. At the same time, the state is refining its state-specific eligibility code. These changes result in uneven enrollment patterns, but the state insists they are correct and that they will smooth out over time. See note about unborn children, which complicates reporting into MAS/BOE 35. In FY 2003, NE imposed cuts in eligibility for working families, causing major declines in child and adult enrollment.
		Retroactive Records	Nebraska decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		Sex	See Unborn Child note.
		TANF/1931	Over time, TANF enrollment in MSIS has been about 15-25 percent higher than ACF data. The state believes this is because there is a separate TANF plan that is not reported to ACF. Nebraska is not reporting any non-TANF eligibles in MAS/BOE 14-17, contrary to expectations. Additionally, until FY 2001, there were 3,000 persons receiving TANF outside of MAS/BOE 14-17.
		Third Party Liability	NE had a significant drop in the number of people with private health insurance from Q4 '99 to Q1 '00.
		Unborn Children	Pregnant women who are only eligible for Medicaid as a result of their unborn child are not entered into the MSIS system. Instead, an MSIS ID is assigned to the unborn child. The unborn child's SSN is 9-filled and the sex is Unknown. The DOB is the expected DOB. After birth, the SSN, sex, and DOB fields are corrected. Most of these unborn children are initially mapped to BOE 5, although some are mapped to BOE 4.

State	File Type	Record Type	Issue
NH	Claims	Encounter	NH is not yet submitting encounter claims. They state in their application that they don't have any managed care, but also say that Medicaid enrollees can voluntarily enroll in one of two HMOs. There are some capitation claims in the OT file.
		LT	There is a large shortfall of LT claims in Q2 1999 due to a mass adjustment that was done to most claims. Since these files were created more than a year after the time file quarter, the state just dropped the original/void pairs and keep the resubmission as an original. These claims will occur in a later quarter file. This affects Q2/Q3 99 only and will not occur again in later files. The admission date is missing on most claims as that information is not collected on the NH claim form. There aren't any claims with a type of service of mental hospital for the aged, even though that service appears in the state crosswalk.
		OT	About a quarter of the clinic claims do not contain a diagnosis code. There are fewer than expected EPSDT claims as EPSDT status is not required on the MMIS paid claims. EPSDT reporting comes from a different source.
	Eligibility	CHIP Code	New Hampshire operates both M-CHIP and S-CHIP programs, but it only reported its M-CHIP eligibles in MSIS. In FY 2002 Q4, there is a 13 percent discrepancy between MSIS and SEDS M-CHIP counts. The state says that this occurred because the state submitted its MSIS files before all of the CHIP data had been received. The state has been asked to delay submission in the future.
		Dual Eligibility Flag	New Hampshire incorrectly reported in FY 1999 Q1-Q2 that all dual eligibles in MAS/BOE 31 and 32 were QMBs with full Medicaid (DUAL FLAG = 02). In subsequent quarters this problem was corrected, and the vast majority of dual eligibles in MAS/BOE 31 and 32 were reported as QMB onlies (DUAL FLAG = 01). New Hampshire is not including dual eligibles in the SLMB-only, QI-1, QI-2, and QDWI groups in its MSIS data. Therefore, Medicaid eligibles are underreported. The state is working on a plan to include these groups in future MSIS reporting.
		Managed Care	New Hampshire is reporting comprehensive managed care (Plan Type 01) enrollment of 2,172 in its June 1999 MSIS data. The CMS data for the same time period indicate that enrollment was more than double that -- 5,872. The state explored this issue, but was unable to find an explanation. They guessed it could have resulted from the fact that MSIS data contained only the managed care enrollment of case heads. The gap between the two counts converged by June

State	File Type	Record Type	Issue
NH	Eligibility	MAS/BOE	Because New Hampshire is a 209(b) state, the number of eligibles reported in MAS/BOE 11 and 12 is lower than the number receiving SSI, according to the SSA.
		Restricted Benefits Flag	In FY 1999 Q1-2, all persons in MAS/BOE 31 and 32 are correctly reported to have restricted benefits related to dual status, even though they are reported under dual code 02.
		TANF/1931	In New Hampshire's FY 1999-FY 2002 data, all persons in MAS/BOE 14-17 were reported to be TANF eligibles. It is unclear whether any persons other than TANF recipients qualified for Medicaid under 1931 rules.

State	File Type	Record Type	Issue
NJ	Claims	Adjustments	Because of reimbursement system, there are a few original & resubmittals claims with negative amount pd, particularly in the LT
		Crossovers	There was a drop in the percent of crossovers from 9.1 percent in Q199 to 2-3 percent in subsequent quarters. This is due to the processing cycle. In Q199 they were catching up from the 2 previous quarters when there was a shortfall.
		Encounter	There are many encounter claims in the IP, OT and RX files
		LT	The claims from 5-6 inpatient psych hospitals were inadvertently left out of the files prior to FFY 2002. This was fixed starting with Q1 2003. The state doesn't know how long those claims were omitted. A small percentage of the adjustment claims have the wrong sign on the amount paid field.
		OT	There aren't any claims with a type of service of PT/OT.
		RX	All compound drugs are coded COMPOUND in the NDC field The date prescribed is missing
		Service Cd	The service code flag is not always correct in Q1 1999 - the state will fix in future submission
	Eligibility	CHIP Code	NJ reports both its M-CHIP and S-CHIP enrollees into MSIS. Beginning in January 2001, NJ added coverage for SCHIP parents. However, there were problems with MSIS reporting for these enrollees until FY 2002. M-SCHIP parents (state group 380) began to be reported in MSIS current records in FY 2001 Q2, but they were mapped to MAS/BOE 15 (they should have been mapped to MAS/BOE 55), and they were assigned SCHIP code 01 (they should have been assigned SCHIP flag 02). The correct coding for M-SCHIP parents did not appear in current MSIS records until FY 2002. S-SCHIP parents (state groups 497,498, and 499) were not reported in MSIS current records until FY 2002 Q1, when they were correctly reported to MAS/BOE 00 and assigned SCHIP code 03. In FY 2002 Q1, there were about 184,000 correction records in SCHIP for state group 380 (M-SCHIP parents); so some of the reporting problems for M-SCHIP parents may have been corrected for MAX.
		Dual Eligibility Flag	New Jersey does not report any eligibles with dual eligibility flag 01, since the state extends full Medicaid benefits for all aged/disabled up to 100 percent FPL. Between FY 2000 Q1 and FY 2000 Q2, the number of dual eligibles with flag 02 dropped by about 7,000 and increased by roughly the same amount for duals with flag 09. The state assured us that this was not a coding error, however they could not explain this shift.

State	File Type	Record Type	Issue
NJ	Eligibility	Managed Care	There is lag in reporting people enrolled in the NF drug managed care program, because they first have to be verified as residing in the NF that month. This lagged MC enrollment will show up in the retroactive records In New Jersey's MSIS files, about 30,000 persons receive the PLAN TYPE value 08 (Other) in the first month of each quarter. These persons are residents of long term care facilities, and are receiving capitated pharmaceutical coverage. Due to a reporting lag, no one receives this flag in months two and three of any quarter. Data for the second and third months of the quarters are supposed to be reported in subsequent quarters as correction/update records. However, this correction has proved to be problematic. Related to this issue, we do not have Plan IDs for these capitated pharmaceutical plans. In addition, Q2 data for this plan were problematic FY 1999-FY 2001.
		MAS/BOE	Until FY 2002, some aged and disabled waiver enrollees were mistakenly mapped to MAS/BOE 45, instead of MAS/BOE 41 and 42. The state believes that the 2001 mapping problem was fixed through correction records. The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. NJ's MAS/BOE data appear to have a "seam effect," but this is supposedly remedied by retroactive coverage and correction records.
		Race Code	New Jersey reports about 12 percent of its eligibles with an unknown race. Between Q1 and Q4 FY 2002 there was a considerable change in the distribution of enrollees by race, especially for whites and Hispanics/Latinos. In Q1, 31 percent of enrollees were coded as white and 25 percent were coded as Hispanic/Latino, whereas, in Q4, 36 percent were coded as white and 20 percent were coded as Hispanic/Latino. The state was unable to explain this shift.
		Restricted Benefits	Persons with restricted benefits flag 5 are generally in waivers and do not qualify for full Medicaid benefits.
		TANF/1931	Some persons in MAS/BOE 44 receive TANF. This is not an error. The state reports that they do receive TANF, but that they are not 1931 eligibles (I.e. they are mapped correctly, and do not belong in MAS/BOE 14). In December 2001, MSIS data report 20 percent more TANF enrollees than data from the Administration for Children and Families. The state was unable to explain this discrepancy.
	Eligibilty	TANF	In December 2001, MSIS data show 20 percent more TANF enrollees than data from the Administration for Children and Families.

State	File Type	Record Type	Issue
NM	All	All	About 10 percent of the people with claims, do not link with the MSIS EL file.
	Claims	Encounter	There are IP (some) and LT (very few) encounter claims. There are many OT and RX encounter claims.
		IP	There are no family planning claims.
			There is a higher than expected percent of records when a Discharge Status of 'still a patient'.
			Approximately one-quarter of the original, non-crossover claims do not have ancillary codes. These include Indian Health Service (IHS) inpatient per diem claims.
			There are many more crossover claims than non-crossover claims, because dually eligible recipients are not in managed care, and virtually all other recipients are.
			50 percent of quarter 1 1999 claims are adjustment claims, due to a DRG reprocessing for Grouper 12 recovery conducted during the quarter.
			Approximately one-quarter of the claims do not have DRGs. These include Indian Health Service (IHS) inpatient per diem claims.
		LT	There aren't any claims with a TOS of MH Aged.
			The diagnosis code is missing on nearly all claims.
		OT	Approximately 1/3 of the 1999 Q1-Q3 original, non-crossover claims had a clinic type of service. The state verified this was correct. However, the percent dropped to 11 percent in Q4 99 and then back up to 32 percent in Q1 2000.
			About 25 percent of the claims had CPT service codes in Q1-3 99. This jumped to 45 percent in Q4 99. There was an similar drop in local service codes in Q4 99.
			An increase in the number of Indian Health Service and waiver claims in the Q4 2000 file impacted the type of service distribution.
			The percent of clinic claims fluctuates considerably between some quarters, probably reflecting billing cycles.
			In Q4 2001, there was a big increase in the average amount paid for all OT services. The state has no explanation.
			New Mexico does not currently have a separate Place of Service code for ER. For a UB-92 invoice, any line item with a rev code of 450, 451, or 452 would be considered an emergency room place of service. The State does not have the information needed to capture ER place of service on their physician/clinic claims.

State	File Type	Record Type	Issue
NM	Eligibility	CHIP Code	Enrollment in New Mexico's M-CHIP program is first reported in FY 1999 Q2, month 3. Enrollment from FY 1999 Q2 - FY 2000 Q3 are somewhat inconsistent with SEDS, but the state assures us that the data are correct. By FY 2000 Q4, the data in the two systems are comparable. The state does not have an S-CHIP program. M-CHIP children are mapped to MAS/BOE 54.
		Dual Eligibility Flag	New Mexico does not report persons in dual flags 03-07 because these enrollees are not part of the MMIS.
		MAS/BOE	Persons in state group 29 mapped to MAS/BOE 45 only qualify for family planning benefits. In Q1 FY 2002, state-specific eligibility group 074 ("working disabled") was incorrectly moved from MAS/BOE 32 to MAS/BOE 15. The group was returned to MAS/BOE 32 in Q2 FY 2002. NM's SSI counts in MAS/BOE 12 exceeded the SSA counts by 11 percent; however, this may occur because NM has a state-administered SSI supplement for residential care. NM does not include SLMB-only, QI, and QDWI enrollees in MSIS. In Q2-Q4 FY 2002, between 200 and 400 persons age 19 or older each month in state groups 032 (133 percent FPL kids) and 036 (185 percent FPL kids) were mapped to MAS/BOE 99, rather than MAS/BOE 34. New Mexico implemented an 1115 waiver in March 1999 for its M-CHIP program, covering children from 185 to 235 percent FPL. An 1115 was used to facilitate the use of copayments.
		Restricted Benefits	Persons (in state group 29) with restricted benefits code 5 only qualify for family planning benefits.
		TANF	NM TANF data are not reliable. The state began 9-filling the TANF FLAG in FY 2003 Q1.

State	File Type	Record Type	Issue
NV	All	MSIS ID	About 7 percent of the people with claims do not link to the MSIS EL files. The reason is not currently known.
	Claims	Encounter	The state is not yet submitting encounter data as they are not yet received reliable encounter claims yet. Encounter claims are processed in a separate system from the FFS claims.
		IP	The diagnosis code fields 2-9 are blank, because the state does not collect this information in its existing system.
			There are no revenue codes on the file, because the state's system does not capture the revenue codes.
			The DRG code is always missing as they don't use DRGs for hospital reimbursement.
			The state puts state-defined codes in the IP procedure code field that just report the type of hospital stay - like medical/surgical 1 -5 days stay.
		IP, LT, OT	In 1999 the diagnosis codes are padded with zeros. All diagnosis codes are five digit codes, as a result. This was fixed for the most part starting with Q1 2000.
		IP/LT	There are some FFS adjustments that appear to be service tracking claims because of their large amount paid.
		LT	The files do not include leave days. Diagnosis codes were missing on most claims in 1999, but are reported for the most part starting with the 2000 files.
			In Q1 99 on original claims, the admission year is 1997, 1998, or 1999. These dates are the beginning date of service in most cases, so the field should be '9'-filled instead. In Q4 99, the field is mostly '9' filled.
			Medicaid IP Covered Days are missing.
			There are very few claims with a type of service 02 (MH for Aged) or 04 (IP Psych. < 21).
		OT	About 40 percent percent of the original claims are for Lab/X-ray services (this is a high percentage).
			There are no revenue codes on outpatient hospital department claims. These claims do have service codes, however.
			The Provider ID Servicing Number and Provider Specialty codes are missing.
			There isn't any PHP enrollment, but there are a few PHP capitation claims in the file with unexpected payments in Q1-3 2000.

State	File Type	Record Type	Issue
NV	Claims	OT	Only 4 percent of the original claims are physician claims (this is a low percentage).
		RX	The date prescribed is missing.
			Compound drugs have a code of 'COMPOUND' in the NDC field.
			The new refill indicator field is missing (HCFA error tolerance at 100 percent for this field).
	Eligibility	CHIP Code	Nevada does not report its S-CHIP enrollment. The state does not have an M-CHIP program.
		County Code	Nevada reports eligibles with County Code = 510. These are residents of Carson City. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "025."
		Dual Eligibility Flag	The following dual eligibility groups are not included on Nevada's MSIS file: QDWI (05), QI-1 (06), or QI-2 (07).
		HIC Number	Between 74-76 percent of Nevada's dual eligibles have HIC numbers. We generally expect that at least 95 percent of dual eligibles will have valid HIC numbers.
		Managed Care	Through FY 2000, NV reported all HMO enrollees into one managed care Plan ID in MSIS. CMS managed care data show three managed care plans in Nevada. The state MSIS staff has now identified distinct plans and assigned each a distinct plan ID. This fix was implemented in the FY 2001 files.
			In the three months of FY 1999 Q1, there are 2,841, 1,304, and 47 persons who are mapped to MAS/BOE 00 and incorrectly receive Plan Type 88 and Plan ID 88888888. This problem was corrected in FY 1999 Q2.
			Until FY 2003 Q3, NV incorrectly identified about 30 Hospice care enrollees as receiving comprehensive managed care. Beginning in FY 2003 Q4, they received plan type code 88: not applicable, as required.
			In FY 2001, there is a 15 percent discrepancy between the CMS managed care count and the MSIS managed care count. Generally, we expect no greater than a 10 percent discrepancy between the figures. CMS and MSIS counts were closer in FY 2002.
		MAS/BOE	A recurring problem in NV is that there are between 5-30 persons each month with valid BOEs, but MAS = 0.
			Although all SSI recipients would qualify for Medicaid, Nevada requires them to apply separately for Medicaid coverage. Monthly data show enrollment in MAS/BOE 11-12 about 7 percent below SSI enrollment levels.

State	File Type	Record Type	Issue
NV	Eligibility	TANF/1931	Over 96 percent of the enrollees in MAS/BOE 14-17 are reported to receive TANF. This proportion is greater than expected.

State	File Type	Record Type	Issue
NY	Claims	Encounter	There are encounter claims on the IP, OT, and RX files.
		IP	There are a large number of service tracking claims in the 1999 IP files. These are probably the Lombardi program payments. The Type of Claim was changed to '9' during the Valids processing. These claims can be identified with a TOC = 9 and Adjustment Indicator = 5. The TOC value was changed because the MSIS IDs did not start with an '@' as required for service tracking claims. 40 percent of the claims do not have an Amount Charged in 1999. The state notes that this is OK: "Our claims processing and payment system often utilizes our Procedure File fee schedules and Provider Rate File amounts to determine payments and not the "Amount Charged" entered by provider. For our rate based service categories, i.e. Clinics, we simply pay the rate amount on our files and do not necessarily validate the 'Amount Charged' amount, if any is entered." DRGs - New York uses a DRG reimbursement methodology, except for certain psychiatric and rehabilitative services which New York pays under a per diem system. The DRG methodology is based on HCFA principles and Grouper, with additional New York State-specific DRGs. These State-specific DRGs, their source codes and descriptions are included in an attachment to the application. NY uses rate codes instead of UB-92 Revenue Codes
		IP/OT	The NYS Medicaid program does not utilize the UB-92 Claim Form for Hospital Inpatient services nor the HCFA-1500 Claim Form for Hospital Outpatient services. Instead the state uses the EMC Version 4.0 or 5.0. The state has its own rate codes that is included as an attachment with its application. Therefore, there are no UB-92 Revenue Codes on the IP or OT file (Outpatient Hospital Department claims).
		LT	NY submits auxiliary claims with small additional payments for most hospital claims. They are reported as original claims and appropriately do not include covered days. 99 percent of claims have a patient status of 'still a patient' The admission year and diagnosis codes are not available on these claims. Only a small percent of LT claims have a diagnosis code.

State	File Type	Record Type	Issue
NY	Claims	Medicaid Amount Paid	On some original and resubmittal claims, the Medicaid amount paid is negative. Likewise, on some voids and credit adjustments, the Medicaid amount paid is positive. This is OK according to the state, who notes: "Under our system, Long Term Care claims may be negative due to presence of a patient participation amount on our recipient master file. The patient participation amount is the amount a recipient is responsible for toward payment of his long term care services. If, for example, a nursing home submits a claim for $500 and the patient participation amount on our file is $600, the paid claim amount will be a negative $100. The same applies to resubmittals and debit adjustments. As far as voids and credit adjustments, we agree that they should generally be negative, but there may be some exceptions with long term care claims."
		OT	NY was unable to submit PHP (BHO) capitation payment claims in 1999/2000 and the number of PCCM capitation claims was under-reported. Starting in Q2 2001, there are no PCCM capitation claims and the number of PHP (BHO) capitation claims are more than expected. It may be they are being reported for earlier quarters. The ratio of PHP claims to PHP person months of enrollment continues to be not as expected. 71 percent of the claims have local codes. Most of these are state-specific rate codes. The Place of Service is "Home" on 44 percent of the claims. Most of these claims are for HH and PCS. The state does not have FQHC claims in the 1999-2000 files. There are few starting with Q1 2001, but according to the state are probably under-reported.
		Pat Liab	The percent of claims with Patient Liability is lower than expected.
		RX	In Q2-3 1999, the NDC field has leading zeros when it contains a HCPCS code.
		Supp Pay	The large number of supplemental payments are Lombardi payments. The Lombardi program provides case management - and some other services - to the non-institutional LT population. In Q3 1999 these claims are reported as service tracking claims. NY is going to resubmit their OT file to report these as supplemental payments.
	Eligibility	CHIP	New York's M-CHIP data in MSIS differ from SEDS numbers through FY 2001 Q1. After that, they are generally consistent in FY 2001. In FY 2002, M-SCHIP enrollment declined throughout the year, with no enrollment by September 2002. No M-SCHIP enrollment is reported in SEDS for FY 2002. Medicaid officials believe the MSIS data is more reliable. New York reports its M-CHIP eligibles, but does not report its S-CHIP eligibles.

State	File Type	Record Type	Issue
NY	Eligibility	County Code	New York did not use FIPS for the County Code in FY 1999 Q2. This problem was corrected in FY 1999 Q3. The state also provided us with a crosswalk, which included information on the state codes that were in use in Q2, as well as the corresponding FIPS Codes. Additionally, in FY 1999 Q2 all New York Cities are mapped to one state county code "66." It will not be possible to correct these counties using the crosswalk.
		Date of Birth	New York usually reported 90,000-100,000 enrollees with no date of birth. Most, but not all, of these enrollees were reported into child eligibility groups. The state believes that most of the enrollees who do not have dates of birth are unborn children. The state assigns ID numbers to unborn children to make sure that they are eligible for services at birth.
		Dual Eligibility Flag	New York codes over 60 percent of its dual eligible population with dual flag = 09 (individual is entitled to Medicare, but reason for Medicare eligibility is unknown). New York has significant problems identifying its QMB-only (Dual eligible flag = 01) or SLMB-only (Dual eligible flag = 03) populations. The state identifies only about 1,000 QMB onlies and does not identify any SLMB onlies.
		HIC Number	New York is unable to report HIC numbers for its dual eligibles.
		Managed Care	During FY 1999, there were major shifts in the number of eligibles with comprehensive managed care plans and PCCMs. While New York's comprehensive managed care enrollment compares favorably with CMS data, there was a problem with PCCM and PHP enrollment in FY 1999 and FY 2000. The state assured us that the MSIS data are correct and seemed to think that the CMS data flip-flopped PCCM and PHP enrollment. New York's Senior Care Plan is reported as "other" in CMS data, but as "comprehensive" in
		MAS/BOE	The number of poverty-related children and adults mapped to MAS/BOE 34 and 35 is lower than expected. Similarly, the number of eligibles in MAS/BOE 24 and 25 is higher than expected. Finally, no one is being reported into MAS/BOE 31-32 or MAS/BOE 45. NY has an 1115 demonstration extending full Medicaid benefits to childless adults. In FY 2002, major increases in adult enrollment (MAS/BOE 25) occurred as a result of the September 11 terrorist attack.
		Race Code	More than 20 percent of eligibles in New York have an unknown race code. This increased to almost 30 percent during FY 2002 as a result of increases in enrollment due to the September 11 terrorist

State	File Type	Record Type	Issue
NY	Eligibility	Restricted Benefits Flag	NY has a large group of enrollees (over 40,000 each month in Q4 FY 2001) assigned restricted benefits flag 5. Most of these enrollees are reported into MAS/BOE 21-25. Some only qualify for family planning benefits, while others are legal aliens who should have been assigned restricted benefits flag 2 instead. This error will be corrected in FY 2003 data.
		Sex	Each year a large group of eligibles (more than 50,000) are reported with an "unknown" sex code. These are probably in the unborn
		SSI	Relative to the number of aged SSI recipients, New York is reporting about 15-20 percent more eligibles under MAS/BOE 11. This suggests the state may be covering some aged persons under Medicaid as SSI recipients who no longer receive SSI benefits, possibly due to delays in deleting persons from the file who have died.
		SSN	NY assigned over 25,000 SSNs in FY 2001 and FY 2002 to more than one MSIS record. In FY 2002, the proportion of enrollees with SSNs dropped to 84 percent as a result of increases in enrollment due to the September 11 attack

State	File Type	Record Type	Issue
OH	Claims	Encounter	The state is not submitting encounter claims
		LT	Diagnosis codes are missing
			Admission date is missing
			Leave days are missing
			Patient status is missing
		OT	The physician specialty codes are missing
			The percent of EPSDT claims is lower than expected
			The servicing provider IDs are missing
		RX	The new refill indicator is missing
			Days supply is missing
			TPL is missing
	Eligibility	CHIP Code	Ohio has an M-CHIP program, but no S-CHIP program. Ohio is somewhat unusual in that some M-CHIP children are reported into MAS/BOE 12. Since Ohio is a 209(b) state, some disabled children do not quality for Medicaid through the SSI-related provisions. However they are able to quality for CHIP coverage.
		County Code	Ohio incorrectly used state-specific county codes in their FY 1999-FY 2002 files. The state has supplied MPR with a crosswalk, linking together their state county codes with FIPS county codes. This problem was corrected in FY 2003.
		Date of Birth	In Q1 1999 1,675 eligibles have birth dates claiming that the person was born in 1999.
		Dual Eligibility Flag	OH is only able to code 2 values for dual eligibles; 01 (QMB-only) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown).
		Foster Care	Through FY 2001 Q3, a higher than expected proportion of Ohio's foster care children are over age 21. The percentage reaches as high as 7 percent in FY 2001, but is within the expected range of less than 1 percent by Q4 FY 2001. Several thousand children in foster care have two records with different MSIS IDs and the same social security number. The state has been asked to fix this.

State	File Type	Record Type	Issue
OH	Eligibility	MAS/BOE	In January, 2001, child and adult enrollment increased by about 172,000 for an overall gain of 15 percent. According to OH officials, about 133,000 former welfare recipients were reinstated to Medicaid from January to March. Ohio is a 209 (b) state. As such, the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by the Social Security Administration. In FY 2002 and FY 2003 (and FY 2001 to some extent) enrollment seems to decline for the aged and disabled month one to month three of each quarter and then increases noticeably in month one of the following quarter. There also seems to be a surge in enrollment in month one of each quarter for adults and in month two for children. About 133,000 recipients were added through a Medicaid Reinstatement project (in response to problems with Medicaid disenrollment related to welfare reform) that ran from January 2001 through March 2001. As a result, MSIS data show a dramatic increase in enrollment in January 2001 and a dramatic decrease in
		Restricted Benefits	Ohio has a sizeable group of eligibles (about 3000) in MAS/BOE 11-12 with restricted benefits related to Medicare, which seems odd. This may be related to the state's 209(b) coverage.
		SSNs	OH has several thousand foster care children with two MSIS records, but the same SSN. Researchers might want to combine these
		State-Specific Eligibility Group	In each quarter, a handful of eligibles are missing state-specific eligibility codes.
		TANF/1931	The TANF flag for OH has some limitations. OH is only able to update this data element quarterly, not monthly. As a result, if eligibles leave TANF and move from MAS 1 to MAS 3 or 4 during the quarter, they will still be coded as receiving TANF benefits. That explains why quite a few MAS 3 and 4 persons have TANF.

State	File Type	Record Type	Issue
OK	All	All	Starting with Q3 2003, OK began using new MSIS IDs. They have been asked to convert the 'old' MSIS IDs to the new, starting with Q1 2003. Prior to that, the MSIS files will contain the old MSIS IDs. The state has submitted a cross reference file of old and new MSIS
	Claims		OK resubmitted their Q1 1999 claims files using the new (2003) MSIS IDs. This file did not pass the distributional review and was not loaded into the data warehouse. However, if the Valids tape file is used as input, the MSIS IDs will not match those in other quarters during 1999-2002.
		IP	A higher than expected percent of claims do not have UB-92 codes. This is because claims for the Indian Health Service and residential treatment centers are not billed on a UB-92. However, the Program Type of Indian Health Service appears to be under-reported in the IP file. The residential treatment center claims should be reported in the OT file.
			There aren't any DRGs as the state does not use them for reimbursement.
			There are no Family Planning claims.
		IP/LT/OT	The Medicaid Amount Paid on void claims is sometimes $0, resulting in the over reporting of expenditures for MSIS reports. The state has been asked to correct this, but it may not be fixed until 2002.
		LT	Most claims do not have a diagnosis code until Q2 2003.
			The patient status is missing on most claims until Q2 2003.
		OT	Some of the diagnosis codes may have an extra zero or two because this field is not edited by the state. MPR checks only the 50 most frequent diagnosis codes, and these appeared to be correct.
			PCCM is covered under PHP plans for most people, so what appears to be a shortfall of PCCM capitation claims is in reality OK.
			About 25-30 percent of claims have a type of service of 'other
			In Q1/2 2003 there is a significant decrease in the average paid for HCBS claims.
		RX	The file only has 3 claims with a Program Type of Family Planning
	Eligibility	CHIP Code	From Q2 FY 2001 through Q1 FY 2002, there was a considerable discrepancy between SEDS and MSIS M-CHIP counts. The state believes the SEDS numbers to be inaccurate. The state is looking into correcting the SEDS numbers. However, systems problems may prevent such corrections.
			Oklahoma reports its M-CHIP children in MSIS. The state does not have an S-CHIP program.

State	File Type	Record Type	Issue
OK	Eligibility	Dual Eligibility Flag	Oklahoma does not report any QDWIs, QI-1s, or QI-2s. Information on these groups is stored in a separate manual system.
		Managed Care	Oklahoma reports a significant number of eligibles with Plan Type = 08 (other). The use of "08" reflects the fact that the plan is a hybrid PCCM plan. Under the plan, physicians are capitated for a limited number of common office procedures and lab work. Additional services are provided on a FFS basis. Physicians also provide a case manager role by referring eligibles to specialists, as needed. These individuals are reported under PCCM in the CMS enrollment report. In Q4 FY 2001, OK began a more traditional PCCM program for Native Americans. By Q4 FY 2002, enrollment had reached about 2,000 per month. Enrollees of this plan are reported into plan type 07 (PCCM).
		MAS/BOE	In FY 2001 and FY 2002, about 8,000 individuals in state-specific eligibility groups CB__00 and KB__00 were incorrectly assigned to MAS/BOE 11 and 12 when they should have been assigned to MAS/BOE 31 and 32. These are persons newly covered under the OBRA 86 provisions allowing coverage for full Medicaid benefits to 100 percent FPL. The state began covering this group in November, 1999. (Most of these persons were previously reported into MAS/BOE 31-32 as QMB onlies.) The state intends to fix this problem in its FY 2003 files. Some 1931 eligibles are mapped to groups other than MAS/BOE 14 and 15, explaining why enrollment in MAS/BOE 14-15 is lower than TANF. We would expect all 1931s to be mapped to MAS/BOE 14 and 15. Oklahoma's MAS/BOE 14-15 and 44-45 enrollment fluctuated greatly during FY 1999 Q4 and FY 2000 Q1. We suspect this was caused by difficulties with TANF delinking. Oklahoma cannot identify Title IV-E foster care children. All other foster care children are mapped to MAS/BOE 48, however. Oklahoma is a 209(b) state, using more restrictive rules for Medicaid than SSI.
		MSIS ID	Starting in 2002, OK will have a new fiscal agent who is changing the MSIS IDs. They will resubmit all the 1999-2002 files with the new MSIS IDs as soon as the crosswalk is done between the old and new numbers.
		Restricted Benefits Flag	Most medically needy enrollees have restricted benefits code 5

State	File Type	Record Type	Issue
OK	Eligibility	SSNs	Beginning in FY1999, about 3,000-5,000 SSNs were assigned to more than one record each quarter. However, this problem was down to about 500 per quarter by late FY 2002.The state believes that these duplicates primarily involve newborns, twins, and mothers and their children. The state is unable to correct all the duplicate SSNs, but believes that many of the duplicates assigned to newborns are resolved in future files.
		TANF/1931	Oklahoma cannot identify TANF recipients. They have 9-filled the field.
	Eligiblity	Managed Care	Oklahoma has a hybrid managed care program that combines capitated and case management services. Enrollment for this group is reported under Plan Type 08.

State	File Type	Record Type	Issue
OR	Claims	All	Because so many people are enrolled in managed care, the distribution of FFS services is sometimes unusual.
		Encounter	There are some encounter claims in the IP and OT files.
		IP	There aren't any claims with a patient status of 'still a patient'
			There are 9 state-specific DRGs that aren't flagged as state codes.
		LT	In 1999 Q1 files, the begin date of service was put in admission date field as admit date is missing. After Q1, the field will be coded as missing
			The patient liability field contains both TPL and patient liability. This can't be corrected until the whole system is revised
			There are no crossover claims in 2003.
		OT	The physician specialty is missing on about half the claims.
			There aren't any FFS FQHC claims, although the state has a FQHC program.
			About 1/3 of the claims have a type of service of transportation.
			There is a low percentage of dental claims as most people are enrolled in dental managed care.
			There are some claims with invalid 2 byte state codes, with service code flag = 10.
		RX	There are only original and credit adjustments in the file. The credits are used to void originals. Resubmitted claims are coded as originals.
	Eligibility	CHIP Code	Oregon reports its S-CHIP data in MSIS. The state does not have an M-CHIP program.
		Dual Eligibility Flag	Beginning in FY 2000 Q2, Oregon reviewed the dual eligibility status of their eligibles. They discovered that many were coded incorrectly. As a result, we observed a shift from dual flag = 02 to dual flag = 09.
		Health Insurance	Each month, a couple of thousand people ineligible for Medicaid received a Health Insurance Flag of "1" or "4". All persons who are ineligible each month should have a health insurance code value of

State	File Type	Record Type	Issue
OR	Eligibility	HIC Number	In 1999 Q1, Oregon 0-filled the HIC code for about 12,000 persons who were eligible for Medicaid, but not Medicare. This problem was resolved in 1999 Q2-4, when the field was correctly 8-filled for these eligibles. In FY 2001, several thousand dual eligibles were added. Many of these had only 9-digit HIC numbers, resulting in an increase in the percentage of dual eligibles with invalid HICs. This remains a problem through FY 2002 Q2.
		Managed Care	A complete list of managed care plans and Plan IDs can be accessed at www.omap.hr.state.or.us/managedcareplans/planinfo/. A large disparity exists between the June 1999 CMS and MSIS PCCM enrollment. It appears as if there was an error in the data reported to CMS. The MSIS numbers are consistent with data from the state's website in FY 1999. Additionally, the MSIS, CMS, and state data are consistent in FY 2000 and FY 2001. However, there may be a slight overcount in managed care enrollment for Q1 FY 2001 due to reporting problems.
		MAS/BOE	A handful of people in FY1999 and FY 2000 were incorrectly mapped to MAS/BOE 99.
		Restricted Benefits Flag	In 1999 Q1 about 3,000 people in MAS/BOE 21 & 22 received a restricted benefit flag of 3. This error was resolved in 1999 Q2-4 when these eligibles were correctly assigned the restricted benefit flag
		SSNs	Each quarter, several hundred SSNs are assigned to more than one record.
		TANF	OR's TANF data do not appear reliable, beginning in FY 2002.

State	File Type	Record Type	Issue
PA	Claims	All	The percent of claims paid each month is uneven because the adjudication flow is not always even.
		IP	Some IP claims are billed on non-UB92 claim forms and therefore don't contain UB-92 revenue codes.
			The Charge on void adjustment claims is positive instead of negative.
		LT	The Charge is missing on most claims.
			The Admission Date is missing on about 1/3 of the claims.
			Patient status is missing on most claims as it isn't available in the state system.
		OT	Physician specialty is not available for most physician claims.
			OPD claims are not billed on a UB-92, so there aren't any revenue codes on those claims.
			In 2004 PA is transferring to a new processor (EDS) and they should be better able to report waiver claims.
			There aren't any individual PCCM claims. They are currently being submitted as gross adjustments. They plan to start submitting them in Q1 2003.
			PA believes that the 1999-2002 OT files contain waiver claims, but they can't be identified by Program Type.
			The diagnosis code on some EPSDT screens is 'EPSDT'.
			There are a large number of claims with a TOS of Other and a Place of Service of Home. According to the state, these are not HH
		RX	The Amount Charged is missing on some claims.
			There are a few claims in Q1 1999 with a TOS of clinic.
	Eligibility	CHIP Code	Pennsylvania has an S-CHIP program, but no M-CHIP program. The state does not report its S-CHIP enrollment.
		Dual Eligibility Flag	The dual eligibility flag was 9-filled for all dual eligibles until Q4 FY 2000.
			In Q4 FY 2000, the eligibles assigned dual flags 8 and 9 were reversed by mistake. This was corrected FY 2001 Q1.

State	File Type	Record Type	Issue
PA	Eligibility	Health Insurance	In FY 1999 through Q3 FY 2000, about 17-20 percent of Pennsylvania's Medicaid population had private insurance, which is greater than expected. In Q4 FY 2000, the number of eligibles with private insurance dropped dramatically. Prior to this time, PA officials indicated they were probably overcounting private insurance eligibles, since persons with Black Lung benefits and Workers' Comp benefits were being counted. In addition, they continued to count persons with private insurance who became Medicare eligible as continuing to have private insurance (when that insurance probably
		Managed Care	Pennsylvania shows a substantial increase in enrollment in managed behavioral health care plans across FY 1999, as PA incrementally moved counties into the managed care system. In FY 2000 Q1-3, the increase continued, but was more gradual. PA did not report the approximately 125,000 enrollees of Magellan Behavioral Health that are included in the CMS managed care count until Q4 FY 2000. In addition, PA did not report PCCM enrollment in MSIS until Q4 FY 2000 (152,000/month according to CMS data). Managed care enrollment in PA appears to have been under-counted until July 2000. Until then, the state failed to report any PCCM enrollment. In addition, HMO and BHP enrollment was lower than CMS managed care reports until July 2000.
		MAS/BOE	In FY 1999Q1, about 700 foster care/adoption assistance children in state groups PC34, TC 33, and TC 34 are incorrectly reported in to MAS/BOE 44, causing an under-count in MAS/BOE 48. This problem was corrected in FY 1999 Q2. During the first two months of FY 1999 Q4, there was an increase in enrollment of about 37,000 persons in MAS/BOE 14-15. This change reflects the fact that Pennsylvania had to reinstate some people who improperly were terminated from Medicaid because they no longer received welfare. Enrollment returned to its original level during the third month of the quarter. In Q4 FY 2000, PA made several changes to its MSIS MAS/BOE reporting. Some groups were dropped as part of the change, meaning that they were incorrectly reported prior to this period. For other groups, MAS/BOE mapping changed. As a result, overall enrollment dropped by about 112,000 from Q3 FY 2000 and there were major shifts by MAS/BOE group. Declines in MAS/BOE 14, 15, 21, 32, 35, and 42 were only partially offset by increases in MAS/BOE 41, 44, and 45. The attached chart shows the mapping changes from Q3 FY 2000 to Q4 FY 2000. The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL, (state groups PS40, PS70, PS90, PH00, PH80), explaining why many people in MASOBE 31-32 have full Medicaid benefits.

State	File Type	Record Type	Issue
PA	Eligibility	Restricted Benefits	In PA's FY 2000 Q4 through FY 2002 Q3 files, the restricted benefits flag is miscoded for many dual eligibles in MAS/BOE 21-22, 31-32, and 41-42. In FY 2002 Q3-4, most of the problems are resolved; however, about 2,000 persons in MAS/BOE 31-32 still receive restricted benefits flag 0. The state will fix this in FY 2003. Until FY 2002 Q3, about 18,000 persons in MAS/BOE 45 mistakenly received restricted benefits flag 5: other. They should have received RBF 1: full benefits.

State	File Type	Record Type	Issue
RI	Claims	Adjustments	When a claim is adjusted, RI voids the original claim itself and therefore there isn't any original claim. If a claim is adjusted in the same quarter as the original, then RI will create a 'dummy' original claim. If the claim is adjusted in a later quarter, the original claim will be have been submitted in the MSIS files, so the state will not need to create a 'dummy' original. The voided original claims will be flagged as 'voids' and the Medicaid amount paid will be a negative amount.
		All	The 1999 claims files have serious problems that can't be fixed due to the limitation of the source files (MARS). RI will have to change their system in order to fix most of these problems.
		Encounter	RI is submitting IP and OT encounter claims. There are data quality problems in their encounter data.
		IP	There are only 14 very large TPL payments in the Q1 1999 file. They appear to be service tracking claims. RI was asked to fix in future submissions.
			There is only one UB-92 Revenue Code on each claim because that is all that is available in the source files. Most of claims have an accommodation code and a few have only a ancillary code.
			Very few procedure codes are included in the file.
			There are no DRGs.
		LT	The diagnosis code is missing on most LT claims.
			There are fewer than expected crossover claims.
			There are not claims with a type of service of MH for the Aged in Q1 1999.
			The file does not contain leave days.
		OT	About 30 percent of the claims in the OT file have a type of service of 'other services'.
			There aren't any claims with a Type of Service of PT/OT.
		RX	There aren't any claims with a type of service of Family Planning.
			The Date Prescribed is always missing.
			The quantity on most claims is 0.
		Serv. Tracking	The Medicaid Amount Paid field on all Service Tracking Claims is 9 filled.

State	File Type	Record Type	Issue
RI	Eligibility	1115 Waiver	Rhode Island operates an 1115 waiver program for children and adults. For the 1115 adults in state-specific eligibility groups 71, 73, and 74, the benefits are limited to family planning services. Effective February 2001, Rhode Island also implemented an 1115 program extending benefits to M-CHIP parents (state group CN).
		CHIP Code	Rhode Island reports its M-CHIP children. Beginning in Q2 FY 2001, the state has an M-CHIP program for adults. The state does not have an S-CHIP program. The MSIS CHIP count differs from SEDS in some quarters, but the MSIS numbers appear to be more reliable.
		Correction Records	Beginning in FY 2001, Rhode Island submits an unusually high number of correction records. The state explains that, prior to FY 2001, a programming error caused only 1/5 of their correction records to be included in MSIS. Analysis of Rhode Island's corrections shows that most are not changing key data elements.
		County Code	Rhode Island has a larger than expected number of persons with County Code = 000. These individuals live out of state, so do not receive a valid FIPS code.
		Dual Eligibility Flag	More than 95 percent of Rhode Island's dual eligible population receive the dual flag 09. Rhode Island hopes to be able to use the dual codes 02s and 04s in the future, but they do not know how long this will take. In FY 2000, a MAS/BOE coding flaw resulted in a lower than expected proportion of persons with restricted benefits code 3 being reported to MAS/BOE 31-32.
		Managed Care	Some people with PLAN TYPE = 01 (comprehensive) have 8-filled PLAN IDs. This is caused by a problem with the program used to generate MSIS data. The problem was fixed in FY 2000.
		MAS/BOE	In July 2000, Rhode Island increased its income threshold for the aged and disabled reported into MAS/BOE 41 and 42. This caused many enrollees previously enrolled in MAS/BOE 21 and 22 to move. In Q2 FY 2001, Rhode Island moved a large group of adults previously reported in MAS/BOE 45 to MAS/BOE 55 (state group CN) as it implemented M-CHIP coverage for adults. Rhode Island is not able to report all of its 1931 eligibles into MAS/BOE 14 and 15. Some are currently mapped to MAS/BOE 44 and 45. This is an important data problem since Rhode Island greatly expanded eligibility for adults under its 1931 program.

State	File Type	Record Type	Issue
RI	Eligibility	Restricted Benefits	Women in state groups 71, 73, and 74 only qualify for family planning services. They are assigned restricted benefits flag 04, as are pregnant women. Medically needy enrollees are assigned restricted benefits code 5 ("other"). By mistake, M-CHIP parents in MAS/BOE 55 were assigned restricted benefits flag 9. They should have been assigned flag 1 ("full benefits"). The state has been asked to fix this problem in FY 2002.
		TANF	There is a 12 percent discrepancy with ACF data in FY 2001.
	Encounters	IP	In 2002, the patient status and UB-92 revenue codes are mostly missing.

State	File Type	Record Type	Issue
SC	Claims	Adjustments	The files do not contain any IP/LT/OT adjustment claims. SC expects to be able to start submitting them at the end of 2004.
		Crossovers	Starting in 2003, SC's crossover claims will be reported with a summary record with the coinsurance and deductible amount for all line items and then separate line items with the coinsurance and deductible fields '0' filled.
		Encounter	The files do not contain any encounter claims
		IP	There aren't any claims with a patient status of 'still a patient'
			A large percent of the claims are for crossovers
			The average amount paid on crossover claims is higher than expected in some quarters.
		LT	There are not any claims with a Patient Status of Died or Still a
			The leave days field is '0' filled instead of '9' filled when unknown.
			Admission date and leave days are usually missing.
			Through 2001 submission 1, over 13 percent of claims are for
			The diagnosis codes only available on IP psych claims
		OT	The number of PCCM capitation claims are somewhat lower than expected based on the person months of enrollment in PCCM managed care.
			1999 Q1 file has over a thousand FFS claims with a TOS of 21. This problem was corrected in Q2-4
		RX	The date prescribed is missing.
	Eligibility	CHIP Code	South Carolina reports its M-CHIP enrollment. The state does not have an S-CHIP program.
		County Code	South Carolina submitted files using state county codes instead of FIPS county codes from FY 1999 Q1 to FY 2001 Q2. The state has submitted a crosswalk of state codes to FIPS.
		Date of Birth	South Carolina had some problems with their date of birth variable in 1999 Q2. Some of their records have "9-filled" DOBs. A few other records indicate, implausibly, that the eligible was born in 2000.

State	File Type	Record Type	Issue
SC	Eligibility	Dual Eligibility Flag	South Carolina generally reports only two values for dual eligibles -- 02 (QMB plus full Medicaid) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown). However, in FY 2002 Q3, SC reported a few enrollees (fewer than 50) with dual eligibility flags 03, 06, and 07. In FY 2002 Q4, all enrollees were in dual eligibility groups 02 and 09 again. Through FY 2003 Q3, SC defaulted to dual code 00 in cases where the state could not determine whether an individual was Medicare eligible. The state has agreed to default to 99 in the future. South Carolina does not report any eligibles with dual code 01, since the state extends full Medicaid benefits to all aged/disabled up to 100 percent FPL. In FY1999, about 13 percent of duals were coded with 09. The proportion of duals with 09 grew throughout FY 2000, however. By Q4 of FY 2002, 34 percent of duals received code 09.
		Managed Care	South Carolina's Physician's Enhanced Program (PEP) is a hybrid PCCM program. In MSIS, it is coded as Plan Type 08 ("other"). In CMS data, it has been reported in several categories over time, including "other" (6/99), PCCM (6/00 and 6/02), and PHP (6/01). In 2001, CMS also reports 4,000 enrollees in a "high-risk channeling project" as an other managed care plan. The enrollees in this project are not reported in MSIS as a managed care plan. According to state officials, this plan terminated August 2002.
		MAS/BOE	In FY 2000 Q1 and FY 2001 Q1, South Carolina categorized disabled SSI beneficiaries aged 65 and older as "disabled." That is, they were mapped to BOE 2. In FY1999 and the remaining quarters of FY 2000 and FY 2001-FY 2003, these individuals were categorized as aged (BOE 1). SC has a large group of enrollees (about 80,000) in MAS/BOE 44-45 who are enrolled in a family planning waiver, according to state-specific eligibility code 3055. Generally, these enrollees are assigned restricted benefits flag 5. South Carolina exhibits a seam effect between the last month of one quarter and the first month of the next quarter. This problem also affects other fields, most notably Plan Type. It is resolved by their submission of retroactive eligibles.

State	File Type	Record Type	Issue
SC	Eligibility	MAS/BOE	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. In the fall of 2002, SC implemented a SLMB-only program for 135 to 175 percent FPL (state code 1049 mapped to MAS/BOE 31). However, this program only lasted until December 2002. Then, in January 2003, SC implemented a prescription drug only program for low income seniors up to 200 percent FPL. This program -- called the SilveRxCard program, is reported as state-specific eligibility code 1092 and is mapped to MAS/BOE 51. Many of the eligibles also qualify for Medicare cost-sharing as SLMB-only enrollees. Beginning in May 2001, South Carolina reinstated approximately 45,000 persons whose Medicaid eligibility was improperly terminated when they lost welfare benefits.
		Race Code	In each quarter, about 4 percent of South Carolina's eligibles have an "unknown" race.
		Restricted Benefits	A subset of enrollees in MAS/BOE 44-45 are assigned restricted benefit flag code 5 (other) since they only qualify for family planning benefits. Beginning in FY 2003, restricted benefits flag 5 will also be assigned to enrollees in MAS/BOE 51-52, who receive prescription drug benefits only through SC's 1115 waiver for low income seniors.
		TANF	Effective Q2 FY 2002, South Carolina no longer reported TANF data. However, the state 1-filled this data element, instead of 9-filling it. The state will 9-fill this data element in the future.

State	File Type	Record Type	Issue
SD	Claims	Encounter	There are no encounter data in Q199. However, the state in its application stated that managed care encounter data would be included in the claims files. South Dakota only has one plan.
		IP	The state in 1999 Q1 - Q4 mapped Crippled Children's Hospitals to this file (MSIS TOS 01). As a result, the percentage of claims with a Patient Status of '30' is higher than expected. This problem will be corrected for 2000 files, as the claims will be mapped to MSIS TOS 07 and put on the LT file. These claims are identified as having a Provider Number of 021xxxx. Because in 1999, the state is moved some MMIS LT claims to the MSIS IP file, some data elements are not available in quarter 1 for certain claims. Specifically, on five percent of the claims, there are no diagnosis codes, Medicaid IP covered days, or accommodation codes. 15 percent of the claims do not have ancillary codes. The problem was corrected starting with Q3 2000 but in Q4 2000 the problem resurfaces (now 20 percent have no ancillary codes), improving in 01 Q1 and worsening again in 01 Q2 at 11 percent.
		LT	There are no original, non-crossover claims in Q199 with third party liability. The IP covered days are mostly missing on claims with a type of service 04 (IP psych < 21) There are very few diagnosis codes on the file.
		OT	45 percent of physician claims do not have specialty codes. Indian Health Service (IHS) claims are billed on a UB-92, with a Type of Service of 12, Clinic. These claims have revenue codes, but do not have service codes. A much higher than expected percentage of OT claims have a type of service of physician. Virtually everyone is enrolled in Delta Dental managed care. In 1999 the PHP capitation claims are actually encounter claims from Delta Dental with the Medicaid Amount Paid by DD to their providers. Starting in 2000, this problem is straightened out and the file contains the true dental capitation claims with a type of service 21 (PHP).
	Eligibility	CHIP Code	South Dakota reports its M-CHIP children and S-CHIP children. However, the S-CHIP program was not implemented until Q4 2000.
		Dual Eligibility Flag	South Dakota assigns the dual flag 09 to over 50 percent of their dual eligibles, because they cannot correctly identify the dual groups to which these people belong.

State	File Type	Record Type	Issue
SD	Eligibility	Health Insurance	More than 10 percent of the persons in the file are coded as receiving third party insurance. This number is higher than expected, but the state confirms that it is correct.
		Managed Care	SD began reporting dental managed care enrollment in FY 2000. By mistake, this enrollment was not reported in FY 1999.
		Retroactive Records	South Dakota decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	South Dakota has between 400-600 records on each file with duplicate SSNs. The state is aware of the problem and has a process in place to correct it, however most of the process is done manually and takes time. They are a non-SSN state.
		TANF/1931	South Dakota cannot identify their TANF recipients. This field is 9-filled for all eligibles.
	Encounters	OT	There are only encounter claims with a type of service.

State	File Type	Record Type	Issue
TN	Claims	All	Starting in July 2002 and continuing on into some time in 2005, TN has been paying the managed care plans a $10 administrative fee and then paid the plans on a FFS basis for services provided to their members. The claims for these services have been included in the claims files, but are flagged as encounter claims and do not have a Medicaid Amount Paid. In April 2004, TN was asked to resubmit the files back to Q4 2002 changing those encounter claims to FFS and including the Medicaid Amount Paid. Two of the MCOs have been working under that arrangement since July 2001. The MSIS claims files for July 2001 - June 2002 will not be corrected. Starting in July 2002 and continuing on until sometime in 2005, TN has been paying the MCOs an administrative capitation fee ($10) plus reimbursing them on a FFS basis for the services actually provided. This was an attempt to stabilize the managed care plans and is viewed as a temporary situation. TN has flagged those FFS claims as encounters and the Medicaid Amount Paid is $0. However they do have the amount paid in their system. CMS as requested that they resubmit the 2002 Q4 files and forward with the claims flagged as FFS and the Medicaid Amount Paid field containing the amount that was paid for the service.
		Capitation	There was a massive adjustment to capitation claims in August 1999. Until the state becomes current with their submissions, they will only submit original and debit adjustment capitation claims. When an original claim is adjusted in the TN system, the original is replaced with a credit claim, voiding the original and the original no longer exists in their files. In Q3 1999 when the massive adjustment took place, in the state system there are only credit and debit claims that cancel each other out. We requested that until they become current, that they not submit the credit capitation claims.
		Dental	Dental services were also carved out the managed care plans starting with July 1 2002 and they were included in the MSIS files as encounters with $0 paid. TN has been asked to resubmit these claims properly flagged as FFS with the Medicaid Amount Paid.
		Encounter	There are some data quality problems in the encounter records. All services except for LTC are covered by managed care. There are only FFS claims for capitation payments, LTC and for crossovers.
		IP	The IP file only contains encounter and FFS crossover claims due to managed care enrollment.
		LT	There is a big drop in the percent ICF/MR claims in Q4 2000. There is a shortfall of claims in Q4 1999 because state did massive adjustments. They will occur in later quarters.

State	File Type	Record Type	Issue
TN	Claims	LT	There aren't any claims with a Type of Service 02 or 04 in the LT file. However, there are some TOS 04 encounter claims in the IP and OT file in Q1 99. The state has been asked to move them to the LT file in future submissions. LTC services are carved out of managed care so the LT file contains only FFS claims. There is an increase from about 10,000 FFS claims in Q1-3 2000 to about 50,000 in Q4 2000
		OT	There aren't any claims with a Type of Service 02 or 04 in the LT file. However, there are some TOS 04 encounter claims in the IP and OT files. The state has been asked to move them to the LT file in future submissions. All pharmacy services were carved out of managed care beginning with July 1, 2003. The claims for these services also show up in the MSIS files as encounter claims with $0 Medicaid paid. The state will convert these records to FFS with the Medicaid Amount Paid added. BHO pharmacy claims have been carved out of managed care since July 1996. TN will not fix and resubmit the MSIS claims files prior to Q1 2003. Finally, the pharmacy claims for dual eligible were carved out of managed care starting with July 2000 and will not be corrected prior to Q1 2003. Dental services were carved out from the MCOs starting with October 2002 and administered by a Dental Benefits Manager (DBM). Claims for those services were also included in the MSIS claims files, but again as encounter claims, not FFS. These claims will be converted to FFS and the Medicaid Amount Paid included and resubmitted to CMS starting with Q1 2003 (Oct. 2002).
		OT/LT/IP	From July 2002 - December 2003, TN stopped paying the HMOs the full capitation payment. During that time, the HMOs were paid a $10 administrative fee and then the state paid the services provided by the HMOs on a FFS basis. However, the clams for these services are not included in the file.
		RX	Starting in 7/96, all BHO pharmacy services were carved out of managed care and starting with July 2000 the pharmacy claims for duals were carved out. TN began carving out all the remaining pharmacy services starting with July 2003. These services were submitted as encounter claims with $0 Medicaid paid. The expenditures have not been reported as service tracking claims. This results in a vast under-reporting of RX expenditures in the MSIS files. CMS has requested that TN resubmit the MSIS files starting with 2002 Q4 with the corrected Medicaid Amount paid and the claims flagged as FFS, not encounter. Any expenditures they can not report as individual claims will be submitted as service tracking.

State	File Type	Record Type	Issue
TN	Eligibility	CHIP Code	Tennessee has an M-CHIP program, but no S-CHIP program. During FY 1999-FY 2002, the data varies widely from CMS' SEDS system. The state could not explain the discrepancy. In addition, the M-CHIP data in MSIS approximately doubles in Q1 FY 2001, due to growth in state group 87 ("TennCare Uninsured"). This increase does not appear in the SEDS numbers. However, MSIS and SEDS are consistent in that both data sets show a gradual decline in M-CHIP enrollment across FY 2001 and FY 2002. The M-CHIP program phased out by FY 2003.
		Dual Eligibility Flag	Roughly half of Tennessee's dual eligibility population received the dual eligibility flag 08. Many of these duals qualified through the TennCare 1115 Waiver expansion. The state did not buy into Part B Medicare for these persons.
		MAS/BOE	Tennessee reported a much higher number of eligibles in MAS/BOE 11 and 12 than expected, given the number of SSI recipients in the state. This may relate to a long-standing court case, requiring the state to maintain Medicaid eligibility for persons leaving SSI. After many quarters of growth, child and adult enrollment dropped about 4 percent in January 2002 (cause unknown). In FY 2003, enrollment in MAS/BOE 52-55 declined, presumably related to cutbacks in TennCare resulting from reverification efforts. Although increases were reported for MAS/BOE 14-15, 24-25, and 34, total child and adult enrollment declined. In FY 1999 Q1-4, over 4,000 individuals younger than age 65 were reported into MAS/BOE 31. This problem was generally corrected in FY 2000 Q1. However, it began to recur in FY 2002.
		TANF/1931	Tennessee under-reported the number of TANF recipients in their FY 1999 MSIS files. The state corrected this issue over time, so that by FY 2002 the numbers were very close. Tennessee reported that all eligibles in MAS/BOE 14-17 were TANF recipients. It is not clear whether any persons other than TANF eligibles qualified under the 1931 rules.
	Encounter	OT	The type of service is missing on about 10 percent of the claims and there are very few different type of service codes. The file contains about 4,000 claims with a type of service of IP Psych < 21. These claims should be reported in the LT file.
		RX	The NDC is missing on adjustment claims. The type of service is missing on most claims.
	Encounters		The Fill Date is always missing and the Prescribed Date is reported.

State	File Type	Record Type	Issue
TX	Claims	All	The Provider ID Numbering system was changed Q3 2001. The old and new IDs need to be crosswalked in order to adjust claims. In Q4 2002, TX started a patient co-pay program. These payments can only be reported in the LT file in the patient liability field. TX initiated a co-payment program for Medicaid in December 2002. These co-payments can not be included in the IP, OT or RX files as there isn't a patient liability variable.
		Crossover	There are a few crossover claims with very large Medicare Coinsurance and/or Deductible Amounts Paid. TX will code the Coinsurance field as 99996 and put the Medicaid Amount Paid in the Deductible field.
		Encounter	The state does not have encounter data.
		IP	Texas uses the following procedure codes: "MXXX" and "KXXX"; these are codes on the National Heritage Insurance Company (NHIC) Procedure Master File. NHIC previously used these codes for: MXXX: Medicaid prior approval; KXXX: Chronically Ill Disabled Children (CIDC) Inpatient Prior Authorization.
		IP/OT	TX sometimes receives claims with erroneous TPL amounts that are so large they won't fit in the TPL field. TX will '9' fill the field and it will be converted to '0' in the MSIS Valids file, appearing that there wasn’t any TPL paid.
		LT	There are credit adjustments, but very few debit adjustments. The state voids out the original claim, but calls this void a "credit adjustment" in MSIS. The resubmittal claims are coded as original claims. For 2000, however, they will likely be able to code the original claims as debit adjustments. Patient status is mostly missing. Through 2000 Q4, and for all of 1999, LT files are missing the following data elements: Admission Date, Patient Liability, and TPL. The following variables are missing in the Q1 1999 file: Diagnosis and Covered Days. The following variables are missing in the 1999 files, but are reported starting with Q1 2000; Charge, Leave Days, Patient Liability. The state had to build the Q1 1999 file from very incomplete old records. NHIC's new claims system promises much more complete data starting Q3 2000. from a Long Term Care claims history file that did not contain data essential to MSIS reporting. This was due to a new Long Term Care Claims Management System that was developed, however, the history data was not available for MSIS processing." Texas expects to have these data for FY 2000 because their system will have captured these data.

State	File Type	Record Type	Issue
TX	Claims	OT	The TPL is not on most claims because it is carried at the header level. Texas will create a 'dummy' claim with the TPL for 2000. To create these dummy claims for 1999 would delay the submission of 1999 tapes.
			The Place of Service is missing or invalid on about 15 percent of the claims.
			About 8 percent of the claims have the invalid combination of an 8 filled service code flag and a service code value of 0. Some claims have invalid service codes.
			Capitation claims from the NorthStar managed care program (BHO) are reported with a TOS of 20 (HMO) instead of TOS 21 (PHP). TX will fix this in the future.
			There is a big change in the distribution of claims by type of service starting with Q3 2001 because the state changed its system and in the process reviewed how they were assigning type of service. The revised hierarchy they began using in Q3 2001 results in many more lab/Xray services being pulled out of physician, clinic, etc. claim and being put in lab/xray where they belong. Currently their Q3 2001 claims from NHIC does not have any claims reported with a TOS of 19. This is clearly an error and they are investigating.
			In Q2 1999, 5 percent of the services codes aren't valid.
			The TPL is not on most claims because it is carried at the header level. Texas planned to create a 'dummy' claim with the TPL for 2000, but hasn't been able to do it.
			The Q2 and Q4 OT files have some claims with a date of adjudication prior to the quarter.
			There aren't any claims with UB-92 codes in Q2-Q3
			In Q4 1999 almost 2 percent of the claims have the invalid diagnosis code of ' 02'.
			There are a few claims in Q4 1999 with dates of service after the quarter.
			The PCCM $3 fee is included with any expenditures for medical services during the visit and can not be separated because of the adjustment process. So the only PCCM capitation claims are those that are paid for case management only. The combination claims (PCCM + service) are assigned the TOS based on the medical
			There are very few claims with a Type of Service of Other Practitioner and a much higher than expected percent of claims with a Type of Service of Physician.
		RX	No claims have a Third Party Liability.

State	File Type	Record Type	Issue
TX	Claims	RX	About 0.2 percent of the claims have an NDC code of
		Sources	TX has a large number of state agencies responsible for the administration and process of Medicaid claims for different parts of the program making it difficult for them to collect and report Medicaid services uniformly in MSIS
		TOS	Due to a system change, a new TOS crosswalk will need to be created for the 2000 files. A new MMIS is to be installed in August 2001 and will again require a new TOS crosswalk and careful review of their files.
		Transportation	The capitation payments for transportation managed care are paid to providers once a month as a lump sum payment.
	Eligibility	CHIP Code	Texas reported its M-CHIP children until it phased out in Q1 FY 2003. The state's S-CHIP program, which began in April, 2000, is not reported into MSIS.
		Dual Eligibility Flag	Texas assigns the dual eligibility flag 08 to about 15-17 percent of its dual eligibility population. Most are reported in MAS/BOE 41 and 42. Texas does not automatically buy-in to Medicare for persons in these groups. In addition, some 08s are SSI recipients in MAS/BOE 11 and 12 whose exact dual status has not yet been determined.
		Managed Care	Texas began to report a behavioral managed care plan in July 1999. Beginning in FY 2000 Q1, Texas exhibits a significant upswing in PCCM (Plan Type 07), Comprehensive Managed Care (Plan Type 01), and Behavioral Managed Care (Plan Type 03). The numbers in MSIS are consistent with what we see in external CMS data, although there was a PCCM discrepancy in FY 2002 (the state believes the MSIS numbers are more accurate). Enrollment in these groups continues through FY 2002. In July 2002, private health insurance reporting increased to about 147,000 from about 120,000 in June 2002. The state believes this to be correct.
		MAS/BOE	From FY 1999 Q1-FY 2002 Q2, Texas reports about 2,000 to 3,000 eligibles in MAS/BOE 55. These eligibles are not part of an 1115 Waiver. Rather, the individuals are made eligible through a TANF waiver, which extended Medicaid benefits after the individual's state time limit had expired. The waiver expired 3/31/02, but the eligibility created by the waiver continued. Because the waiver expired, this group was moved to MAS/BOE 45 in FY 2002 Q3. TX began reporting BCCPTA enrollees under MAS/BOE 3A in Q1 FY 2003.
		Restricted Benefits	TX assigns code 5 ("other") to aged and disabled LTC persons in MAS/BOE 41-42 who are living at home.

State	File Type	Record Type	Issue
TX	Eligibility	SSN	TX reports about 500 duplicate SSNs each quarter. The state is aware of the problem and periodically works at reducing it.
		State-Specific Eligibility Group	The state-specific eligibility group field is 8-filled for QI1s, QI2s, and QDWIs.
		TANF/1931	Some non-TANF 1931 eligibles appear outside MAS/BOE 14-17. As a result, virtually everyone in MAS/BOE 14-17 receives TANF. The number of TANF recipients differs somewhat from the number reported by the Administration for Children and Families. The MSIS data use a later cut-off date than the ACF data.

State	File Type	Record Type	Issue
UT	All	MSIS ID	About 5 percent of the people with claims in 1999 do not link to the MSIS EL file because the MSIS IDs do not match. This is in part the result of some BHO capitation claims being submitted with a MC Plan ID instead of MSIS ID. UT is changing its MSIS IDs to a new numbering scheme in Q4
	Claims	Capitation	There are not any PCCM capitation claims in the OT file even though the state has a PCCM program. There are very few capitation claims for people enrolled in HMOs in 1999 and Q1/Q2 2000. The HMO capitation claims were added starting in Q3 2000. (UT resubmitted the Q1/Q2 OT file and was unable to include the HMO capitation claims as those source files had been lost in the state system.)
		Encounter	The state is not submitting encounter data. Utah is receiving very minimal encounter data on a few people from the managed care plans. Currently their contracts don't require many variables including diagnosis and service codes, and the contracts will need to be modified in order for the state to collect the MSIS data elements. UT will notify both CMS and MPR when they expect to be able to start submitting encounter data.
		IP	No one is reported as still being a patient.
		LT	The ‘admission date' and ‘patient status' are missing on most nursing home/institutional claims because Utah does not retain the data on the input record.
		OT	The average expenditure for claims with a type of service clinic jumped from about $400 to $700 in Q3 1999 and continued at the $700+ level in 2000 Most claims for children have a Program Type of EPSDT The 2002 Q3/4 OT files do not contain any claims with a place of service of ER. Place of Service are missing on over 20 percent of the Quarter 1, Original Non-crossover claims. Utah accepts a place-of-service code of ‘other' from providers. Since this cannot be translated, a high number of claims will have the ‘99' value (unknown or not listed). The physician specialty code is missing on over 60 percent of the Quarter 1, Original Non-crossover claims. There are several explanations. First, physicians in a group practice do not have their specialties listed. Second, Osteopaths and podiatrists have no specialty code assigned them under Utah's coding system. Some BHO (PHP) capitation claims do not use the MSIS ID.

State	File Type	Record Type	Issue
UT	Eligibility	1115 Waiver	Utah's 1115 Waiver program is its Primary Care Network, implemented in July 2002. The program expands Medicaid coverage to cover adults up to 150 percent FPL and pregnant women with assets exceeding the allowable levels for Medicaid. The state neglected to include 1115 reporting in its FY 2002 Q4 data.
		CHIP Code	Utah reported enrollment in its S-CHIP program in MSIS. The state does not have an M-CHIP program.
		County Code	Utah uses a state-specific county code in FY 1999 and FY 2000, instead of the FIPS county codes. This problem will be corrected in their FY 2001 files. The state supplied MPR with a crosswalk that links together the state county information with the correct FIPS county code.
		Dual Eligibility Flag	Utah provides full Medicaid benefits up to 100 percent FPL for its aged and disabled recipients. As a result, many eligibles in MAS/BOE 31 and 32 receive full Medicaid benefits. Utah does not buy into Part A Medicare coverage for duals. Also, the state reported a larger-than-expected number of 08s. Between 85-90 percent of persons older than age 64 are reported as dual eligibles, a somewhat lower than expected proportion. Some persons in MAS/BOE 21-22 and 41-42 are reported to have dual codes 01 and 03. State officials say this is due to a timing problem. Both dual eligibles who have to spend down to qualify for full Medicaid benefits (through the medically needy program) and those who contribute to the cost of their institutional care are not initially classified as qualifying for full Medicaid benefits. The number of QMB-only dual eligibles (dual eligibility flag = 01) is much lower in FY 2000 Q1 than in any of the other FY 1999 or FY 2000 quarters. In FY 2000 Q1, there are roughly 250 QMB onlies, whereas there are about 1,000 per quarter in the rest of the FY 1999 and FY 2000 quarters.
		Health Insurance	Utah reported about 10 percent of its eligibles with private health insurance, a somewhat higher than expected proportion. The state has confirmed that this proportion is correct.
		Managed Care	Utah does not report PCCM enrollment or claims or transportation enrollment or claims, even though PCCM and transportation enrollment is reported in CMS managed care reports. State officials indicate no PCCM capitation payments are involved. For the transportation coverage, individual records are not maintained in the MMIS.

State	File Type	Record Type	Issue
UT	Eligibility	MAS/BOE	Prior to FY 2000 Q4, Utah had been under-counting the number of poverty-related children. During this time, roughly 30,000 had been assigned state-specific eligibility codes which caused them to be mapped to MAS/BOE 44. Beginning in FY 2000 Q4, this problem was corrected. These children were correctly assigned to state-specific eligibility codes which are mapped to MAS/BOE 34. In FY 1999, FY 2000, and FY 2001, MAS/BOE was incorrectly assigned for about 36 state-specific groups. Many (but not all) were reported into MAS/BOE 31-35 when they should have been reported into MAS/BOE 14-15 and 41-45. This represented about 15 percent of monthly enrollment in FY 2001. Groups that were mismapped included some 1931 eligibles, some of the institutionalized qualifying under the 300 percent FPL rules, the working disabled, TMA enrollees, and persons meeting AFDC rules, but not qualifying for
		Restricted Benefits Flag	Some eligibles outside of MAS/BOE 31 and 32 receive RBF = 3 (restricted benefits based on dual eligibility status).
		SSI	Utah requires a separate Medicaid application for its SSI recipients. As a result, the number of MAS/BOE 11 and 12 eligibles was lower than the number receiving SSI.
		TANF	The TANF flag was not reliable in FY 2000, but it looks reasonable for FY 2001 forward.

State	File Type	Record Type	Issue
VA	All		VA is implementing a new system in March 2003 and they can not make any changes to their current systems until then.
	Claims	Capitation	PCCM capitation claims are not included in the 1999-2000 files.
		Encounter	There are encounter claims in the IP, LT and OT files beginning in Q1 1999. The RX file has encounter claims starting with Q1 2000.
		IP	DRGs are not currently available in the claims files as VA assigns DRG as a post payment process solely for cost settlement. The state expects to start submitting them beginning with Q2 2000. The percent of claims where the person is still a patient is somewhat higher than expected. Over 20 percent of the 1999 and Q1 2000 claims have a Medicaid Amount Paid of $0 as there is a 21 day limit for adult IP care. Expenditure after 21 days are paid as a cost settlement.
		LT	The percent of claims with patient liability is less than expected. This is because the providers aren't always consistent about including that information on the claims. Leave days are not carried in the state's claims files. Patient status is mostly missing.
		OT	VA was unable to submit HMO capitation claims for the first 2 months of FFY Q1 1999 because they had aged off the system. The servicing and billing provider ID numbers are usually the same. When available they are putting the attending provider ID in the servicing field. Transportation: VA pays a capitation rate to various county based agencies for transportation services. The payment is based on the estimated number of Medicaid enrollees, not for specific enrollees. Until Q4 2004 these capitation payments were not in MSIS either as service tracking or individual capitation claims. People covered by transportation managed care were not flagged in the MSIS EL files as enrolled in Other MC. Starting with Q4 2004 the transportation capitation claims will be included as service tracking claims and enrollees will be in the EL file in Other MC. The percent of claims with CPT-4 codes dropped from 81 percent in Q1 1999 to 67 percent in Q4. This is the result of the movement of some FFS recipients to managed care.
		RX	VA does not have the capacity of using HCPCS inputs on pharmacy claims. Universal codes are used for DMEs without NDCs. Pharmacy claims without NDCs can be compounds or other

State	File Type	Record Type	Issue
VA	Claims/HMO	Capitation	Files will be missing HMO capitation payments from 10/98 and 11/98 (FY 1999Q1).
	Eligibility	CHIP Code	Until the fall of 2002, VA only had an S-CHIP program, and was reporting all of its S-CHIP eligibles into MSIS. The numbers in MSIS are greater than in SEDS until Q4 FY 2001. The state assures us that the MSIS numbers are correct; however, there may also have been some problems with double counting. SEDS and MSIS are comparable beginning in Q4 FY 2001. Effective September 2002, the state has an M-CHIP program as well, and many children appear to transfer from S-CHIP to M-CHIP.
		County Code	Virginia assigns special FIPS codes 510-840 to cities that are independent entities. Virginia assigns county codes 983-997 to institutions in the state.
		Health Insurance	In Q199, there were about 12,000 Medicaid eligibles each month who were reported as "ineligible" in the HEALTH INSURANCE field. This problem was corrected in the Q299 - Q499 files.
		Managed Care	In FY1999 Q3, the mix of HMOs changed somewhat and overall HMO enrollment increased, while PCCM enrollment declined. Another shift in managed care enrollment occurred in Q1 FY 2002, with PCCM enrollment declining and HMO enrollment increasing.
		MAS/BOE	After July 2000, the state began bypassing the 1931 rules for children. Virginia now determines eligibility for children based on the more simplified poverty-related provisions (MAS 3). The state has continued to use the 1931 rules to determine eligibility for adults, but they are unable to separate 1931 eligibles from other transitional assistance recipients. Both groups are under one state-specific eligibility group that is mapped to MAS 4. Virginia is a 209(b) state. As a result, SSI recipients are required to fill out separate applications for Medicaid, and are required to meet stricter standards. Because of this, the total number of persons in MAS/BOE 11 and 12 is less than the number reported by the SSA. Beginning in Q4 FY 2001, VA extends full Medicaid benefits to aged and disabled persons to 80 percent FPL (state groups 29, 39, and 49). Many of these persons were incorrectly assigned dual code 01 and restricted benefits code 3. They should have been assigned restricted benefits code 1. The correct dual code would be 02 if they were dual eligibles. This problem was fixed in FY03 Q4. Virginia begins reporting BCCA eligibles in FY 2001 Q4.

State	File Type	Record Type	Issue
VA	Eligibility	MAS/BOE	Effective FY 2003, Virginia has an 1115 program to extend family planning services to enrollees in MAS/BOE 55 (state group 80). VA has an outreach program to children in September of each year. Enrollment is retroactive three months.
		Restricted Benefits	Persons in state group 80 (Family Planning Waiver) are assigned restricted benefits code 4. In some (but not all) quarters BCCPTA women (state group 66) are assigned restricted benefits code 5. Finally, many medically needy persons are assigned restricted benefits code 5.
		SSN	VA put 3 leading 8s and then a date (usually the date of birth) in the SSN field when the SSN is unknown. This caused many records to have duplicate SSNs, plus it was incorrect. Unknown SSNs should be 9-filled. This was corrected starting with Q4 FY 2002, according to the state. However, some level of duplicate SSNs will continue even after 9-filling since people can have more than one MSIS ID if they change cases over time.
		TANF/1931	TANF data are not reliable in VA. The state began 9-filling the TANF field in late FY 2003.

State	File Type	Record Type	Issue
VT	Claims	All	Across the four files, there are fewer than expected adjustment claims. Specifically, less than 1 percent of the claims are adjustment
		IP	About half the claims are for crossovers in 1999.
			The state does not use DRGs.
		LT	There are no original, non-crossover Q1 1999 claims with a type of service of 05, ICF/MR. However, this was a one quarter correction and they occur in subsequent quarters.
		OT	VT stopped including Physician Specialty in Q3 1999.
			The State has State-specific Revenue Codes for Home Health and Hospice Services.
			About 1/3 of the 1999 claims have a Type of Service of '19': Other Services. In 2000 that percent started to decline and in Q3 2000 it was only 19 percent.
			The number of claims jumps from about 482,000 in Q2 2000 to 670,000 in Q3.
			All QMB-only, SLMB-only, and QI1 eVermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).
			Through 2000, all OT claims, regardless of type of service, have something in the diagnosis code field.
		RX	There was a big increase in the number of RX claims between Q1 and Q2 1999.
	Eligibility	CHIP Code	Vermont reports its S-CHIP eligibles into MSIS. The state does not have an M-CHIP program.
		Correction Records	Each quarter, Vermont submits a few correction records that are very old (up to about 20 years old). The number of such records is small and the state does not think this practice has an effect on its data.
		Dual Eligibility Flag	All QMB-only, SLMB-only, and QI1 eligibles are reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).
		Managed Care	Beginning in FY 2000Q1, Vermont transitions everyone with Plan Type = 01 (Comprehensive Managed Care) into Plan Type = 07 (PCCM). This change was made because the state's two managed care plans (Blue Cross and Kaiser) left the program.
			PCCM enrollment started Q1 2000.

State	File Type	Record Type	Issue
VT	Eligibility	MAS/BOE	Beginning in 1995, Vermont implemented a 1115 waiver program -- Vermont Health Access Plan (VHAP) -- that extends eligibility with full benefits to children and adults. Aged and disabled enrollees under the 1115 waiver are dual eligibles who qualify for prescription benefits, plus Medicare cost-sharing. In FY 2001 and FY 2002, VT's counts of aged SSI eligibles are about 20 percent higher than SSA administrative data. No eligibles are mapped to MAS/BOE 31 and 32, because all QMB-only, SLMB-only, and QI1 eligibles are reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate). In FY 2001, Vermont stopped reporting into MAS/BOE 16-17 (optional reporting groups), instead reporting all TANF eligibles into MAS/BOE 14-15. In FY 1999 through FY 2003 Q2, enrollees of state-specific eligibility groups RR and R1 were mistakenly included in MSIS. These are members of the Refugee Resettlement Program. 200 or fewer persons are enrolled in the program each month. These enrollees will be mapped to MAS/BOE 00 beginning in FY 2003 Q3. In FY 2001 Q1-Q2, a few hundred persons were reported into MAS/BOE 97. These persons are not Medicaid eligible. In FY 2002, approximately ten people each month were mapped to MAS/BOE 39. These are enrollees of state-specific eligibility groups BG and BH. They are BCCPT enrollees and should have been mapped to MAS/BOE 3A.
		PCCM	The PCCM program started Q1 2000.
		Restricted Benefits	Restricted benefits flag 5 ("other") is assigned to enrollees of Vermont's 1115 demonstration, which provides aged and disabled QMB-only/SLMB-only dual eligibles with pharmacy benefits only.
		TANF/1931	Until FY 2000 Q3, everyone in MAS/BOE 14-17 received TANF benefits. There were some 1931 eligibles on the file who did not receive TANF benefits during this period, but those persons were mapped to MAS/BOE 44 and 45 in aid categories TC, T5, TR, and

State	File Type	Record Type	Issue
WA	ALL	MSIS ID	Some claims have some extra 'S's added to the MSIS ID filed in the claims. These need to be dropped in order to match with the EL files. WA puts extra 'S's in the MSIS ID field on some records. These need to be dropped in order to properly link claims and eligibility.
	Claims	Capitation	In Q2-4 2000 there are a few capitation claims with a Type of Service of 19. There aren't any PCCM capitation claims, although there is some PCCM enrollment.
		Encounter	There aren't any encounter claims in the Q1 and Q2 2000 files as none were adjudicated by the state during that time. The managed care claims that were submitted were rejected and resubmitted by the plans and occur in the Q3 2000 and beyond files. This includes waiver claims that are submitted as encounters as they don't include the Medicaid Amount Paid. At the end of CY 2002, the state is working very hard to improve the quality of their encounter data. That means that some quarters will not include as encounter data for awhile when the state rejects it from the MCOs.
		Encounters	The NDC code and days supply are missing on RX encounter claims.
		IP	There were no claims with a Program Type of Family Planning as FP services incidental to other IP services are not classified as FP. The professional component is billed in the OT file.
		LT	Over 99 percent of the claims have a patient status of 'still a patient' which is higher than expected. Also, no one has a patient status of 'died'. The State does not have diagnosis codes on nursing home claims. There are no original, non-crossover claims with a Type of Service of 04 (Child IP Psych.). According to the State, their Mental Health Division is still working on adding this coding system (having TOS 04). Previously, all inpatient psych. claims were lumped together – not broken out by age category. Diana Reitz expects that in the next twelve months, FY 1999, this issue will be fixed. However, it is possible that FY 1999 Q1 LT file will not have TOS 04. The State does not cover Leave Days. The State says: "We don't pay leave days because our providers don't submit them."
		OT	There are some duplicate state-specific service codes with different definitions. They have the save service code indicator. This is under investigation with the state.

State	File Type	Record Type	Issue
WA	Claims	OT	WA did not '8' fill the place of service on the capitation claims on their 1999 files (Q1-Q4). HCFA will raise the error tolerance on these files and ask the state to fix the problem in 2000. HCFA would like to get their files approved, hence the reason that they are raising the error tolerance vs. asking them to resubmit. HCFA will ask the state to properly '8' fill the field on their 2000 files. There are the following state-specific diagnosis codes on the file: V950, v990, and V960). According to the state, "These are valid Washington MMIS codes with the decimal removed as required (i.e. V95.0 -DAY HEALTH CARE; V96.0 -EPSDT/HEALTHY KIDS)."
		Waiver	WA does not include individual claims processed by 6 agencies within the Dept. of Social and Health Services. These agencies are Children's Administration, Juvenile rehab Administration, Mental Health, Division of Developmental Disabilities, Aging and Disabled Administration, Div of Alcohol and Substance Abuse). They were submitted as service tracking claims in the 1999 files with a TOC = 3. They are not included in the 2000 files, but will be included again as service tracking claims in the 2001 and 2002 Q4 files. Starting with 2003, WA is planning to submit the Aged/Disabled Administration services as individual claims with Medicaid Paid. These claims will be missing many important MSIS data elements. The MH services will continue to be submitted as service tracking claims as the individual amount paid is not available. Some of the DD claims can be submitted as individual and others only on the service tracking level. The Alcohol/SA and Juvenile agency claims are now being processed through the MMIS. Service Tracking: The claims for the 6 programs not included as individual claims in 2001 and 2002 will be submitted as service tracking claims with the type of program coded in the billing provider ID field as follows: 11 - Division of Dev. Disability, 12 - MH Disabled, 13 - Div Alcohol & Substance Abuse (WA believes that these are actually included as individual claims in MSIS for this time period, 14 - Aging, 15 - Economic Services Administration, 16 - Children's Admin., 17 Juvenile Rehab Admin. (these are being provided to the state by another source). The service tracking claims will have a date of adjudication of the last date in the quarter that they are submitted. The beginning date of service will be the earliest quarter of payment and the ending date, the latest quarter.
	Eligibility	CHIP Code	Washington operates an S-CHIP program, but does not report enrollment in MSIS. The state does not have an M-CHIP program. Each month in FY 1999-FY 2001, 30 - 60 individuals in MAS/BOE 00 were coded with blank CHIP Codes.
		Date of Death	In FY1999 Q1, 587 individuals were reported to have a DOD before 1998.

State	File Type	Record Type	Issue
WA	Eligibility	Dual Eligibility Flag	In FY 1999, Washington reported some eligibles with Dual Eligibility Flag = 00 and Dual Eligibility Flag = 02 in MAS/BOE 31 and 32. We generally expect that eligibles in MAS/BOE 31 and 32 would receive Dual Eligibility Flags 01, 03, 05, 06, or 07. This problem decreased substantially across FY 1999, however.
		HIC Number	More than 96 percent of Washington's non-dual eligibles had the HIC number 9-filled. The HIC number should be 8-filled for non-dual eligibles.
		Managed Care	From FY 1999-FY 2001, managed care enrollment generally increased from the first month of the quarter to the third. It then decreased somewhat at the beginning of the next quarter. Washington was not reporting claims or enrollment information for its behavioral managed care plan in MSIS during FY 1999, FY 2000, and FY 2001. Enrollment in the plan ranges from about 1.4 million in FY 1999 to about 750,000 in FY 2001. The state is exploring how to report this information in the future.
		MAS/BOE	From FY 1999-FY 2001, enrollment generally declined from month 1 to month 3 in every quarter, and then increased substantially in month 1 of the next quarter, resulting in a "seam effect." Enrollment in MAS/BOE 16-17 declined from roughly 34,000 in June 1999 to less than 1,000 in FY 2000. Enrollment among children and adults grew by over 70,000 (a 10 percent increase) from March to May, 2000, but then declined by 40,000 by the end of FY 2000 Q4. Effective Q4 FY 2001, WA extended family planning benefits to adults in an 1115 demonstration.
		Restricted Benefits Flag	Washington has a problem with the Restricted Benefit Flag (RBF), as it relates to the Dual Eligibility Flag. Many eligibles with Dual Eligible Flags 01, 03, 05, 06, and 07 are reported to have RBF = 1 (individual is entitled to the full scope of Medicaid benefits). These dual eligibility groups should receive RBF = 3 (individual is eligible for Medicaid, but only entitled to restricted benefits based on dual eligibility status). Some discrepancy between the Dual Eligibility Flag and the RBF is expected, since the Dual Eligibility Flag is a root field, and the RBF is a monthly variable. However, this is a greater difference than we expect to see. There is also a problem with the restricted benefits flag for 1115 enrollees. Even though 1115 enrollees only qualify for family planning benefits, they are reported to have restricted benefits flag 1, full benefits.
		TANF/1931	Almost all eligibles in MAS/BOE 14-17 are TANF recipients.

State	File Type	Record Type	Issue
WA	Eligibility	Various Fields	Washington's data are not consistent across variables with regard to the number of persons who are ineligible each month. This problem involves fewer than 300 persons each month from FY 1999Q1-FY 2000Q2. Then, in FY 2000Q3-FY 2000Q4 about 1,200 ineligibles (MAS/BOE 00) each month are not coded as ineligible for the following variables: TANF, RBF, Plan Type 1-4, Plan ID 1-4, CHIP Code. Many of these problems continue in FY 2001.
	Encounter	IP	Only one UB-92 Revenue Code is reported, so if there is an accommodation code, then there isn't a ancillary code.

State	File Type	Record Type	Issue
WI	All	MSIS ID	WI is not an SSN state, but submits their MSIS EL files using SSN rules. They assign Temp Ids to people who don't have a SSN (usually babies) and then when the enrollee gets a SSN they use that for the MSIS ID. WI uses the SSN with an additional byte on the end as their permanent MSIS ID numbers. The extra byte is '0' unless there someone else has previously enrolled in the system with the
	Claims	Adjustments	The files may contain some denied claims.
		Capitation	There are two non-comprehensive plan types that appear on the eligibility file with capitation claims with a TOS of 20. They are Plan ID 65 (PACE) and Plan ID 66 (Other managed care). WI will start reporting the capitation claims for Other Managed Care with a TOS of 21 (PHP) starting with the 2001 files. The PHP capitation rate is very high as it is used to cover ABD managed care services WI changes the date of service to match the date of payment since the HMO capitation claims are made prospectively and their system won't allow payment for a service before it is rendered. This means that if a capitation payment for April is made in March, the dates of service will be changed to March resulting in the capitation payments always being one month prior to the managed care enrollment. Also, this results in the adjustments not linking to the original claims by date of payment.
		OT	WI does not require servicing provider on OPD claims The state system requires diagnosis codes on all claims regardless of TOS ER is under-reported because it is only picked up using UB-92 revenue codes. State plans system change to pick up ER for all ER The void adjustment claims have the span dates on the claim header, while the originals and resubmissions have the line item service date. In FY 2001 Q4, all the waiver claims going back to service dates in January 2000 have been included. They have state-specific procedure codes, no diagnoses, mean expenditure of $553 UB-92 code 001 occurs on many OPD claims as state uses it for rate reimbursement WI has two service codes that can have different meanings but are not distinguishable on the MSIS claims. These codes are W0500 and W0520.
		RX	Prior authorization drugs are coded with eleven '8's

State	File Type	Record Type	Issue
WI	Claims	Waivers	WI submits the waiver claims for a year in the Q3 or Q4 file only due to their processing cycle. The first submission is Q3 2000. This file will probably have some, but not all waiver claims for 1999.
	Eligibility	CHIP Code	Effective FY 2001 Q2, Wisconsin began to cover adults under its CHIP program. M-CHIP adults are reported into MAS/BOE 55. M-CHIP adult counts in MSIS are lower than the SEDS counts because BadgerCare adults with income <100 percent FPL (state group GP) are not considered to be M-CHIP enrollees in MSIS. Wisconsin reported a small number of M-CHIP children until FY1999 Q3, when enrollment increased substantially. M-CHIP children are reported under MAS/BOE 54, since they are part of the state's 1115 Badger Care demonstration. The state does not have a S-CHIP program.
		County Code	For about 10,000 eligibles, Wisconsin reports county codes other than the standard FIPS codes. These codes are for Relief to Needy Indian Person (RNIP) agencies, juvenile correction agencies, Division of Children and Family Services agencies, and Katie Beckett eligibles.
		Dual Eligibility Flag	Wisconsin assigned dual flag 08 to about 25 percent (26,000 persons) of its dual population, a higher proportion than expected.
		Health Insurance	Wisconsin reported about 16 percent of its eligibles with private health insurance, which is somewhat higher than other states report. The state has confirmed that this proportion is correct.
		Managed Care	Each month, about 4,000 eligibles receive Plan Type 08. These eligibles are enrolled in a voluntary managed care program in Milwaukee County called "The Independent Care Plan." The plan covers individuals with physical, developmental, or emotional disabilities and takes care of short-term physician-ordered nursing home stays with prior written approval from the enrollee's HMO. These stays are typically for rehabilitative purposes. A large HMO was terminated in April 2000, causing over 30,000 enrollees to switch to FFS. In June and July 2000, these eligibles enrolled in another HMO.
		MAS/BOE	Beginning in Q399, Wisconsin starts to show substantial enrollment for M-CHIP children (MAS/BOE 54) in its 1115 Badger Care program. Enrollment for adults in MAS/BOE 55 generally starts in Q499. Effective September 2002, WI implemented an 1115 SeniorCare program extending prescription drug benefits to low income aged not otherwise qualified for full Medicaid benefits.
		Race Code	Through Q2 FY 2002, a third of Wisconsin's Medicaid population had the race field coded as "unknown". The proportion is down to one quarter by FY 2002 Q4.

State	File Type	Record Type	Issue
WI	Eligibility	Restricted Benefits	Wisconsin assigned Restricted Benefits Flag 5 ("other") to enrollees who are infected with TB and eligible for TB-related services only. These persons are assigned state-specific eligibility code TR and are mapped to MAS/BOE 44-45. Beginning in September 2002, Flag 5 was also assigned to prescription drug only enrollees in MAS/BOE 51. Beginning in January 2003, Restricted Benefits Flag 5 will be assigned to enrollees of the Family Planning Waiver, who will be mapped to MAS/BOE 54-55.
		SSN	Wisconsin 8-fills SSN field when the recipient is assigned a pseudo-MSIS ID. This explains the larger-than-expected number of persons with 8-filled SSNs. The state assigns permanent SSNs and MSIS IDs in the next quarter, using a retroactive change.
		TANF/1931	Wisconsin is unable to identify TANF recipients. The field is '9' filled for all eligibles.

State	File Type	Record Type	Issue
WV	Claims	All	There was a major system change that affected the 99 Q4 files. WV expects to fix shortfalls in subsequent quarters.
			Due to billing cycle, files contain some claims from month prior to qtr & there is shortfall in the last month of qtr. This also results in very uneven number of claims submitted in each quarter of the MSIS claims files. Major system change needed.
		Capitation	The 1999 and 2000 files do not contain individual HMO capitation claims.
		Encounter	The files do not contain any encounter claims
		IP	No claims with Program Type of family planning
		LT	There aren't any claims with a TOS of MH Aged.
			The percent of claims paid per month were especially uneven - also due to system change. Claims are generally paid once a month, but any particular month's payments schedule can slip into the next
			Diagnosis codes 1-5 are missing on most claims.
		OT	The system change affected the 99 Q4 place of service &average reimbursements.
			In the 1999 Q1 file, there are 11 claims flagged as capitation, that are actually service tracking claims with the average amount paid of $1.3 million
			UB-92 codes not available for 1999 Q2 & mostly missing in 99 Q3.
			The Place of Service of ER under-reported until 1999 Q4.
			There is a big increase in the number of FFS claims in Q3 2000.
			None of the OT claims have state-specific service codes.
		RX	TPL and prescribing physician are missing on all claims.
			There are FP claims in 1999 Q1-4 but not after, due to a system change.
			There are no claims with Program Type of family planning
	Eligibility	CHIP Code	West Virginia first reported its M-CHIP enrollment in June 1999. The state does not report its S-CHIP enrollment.
			West Virginia's M-CHIP enrollment phased out at the end of FY 2000, as West Virginia moved to become an S-CHIP only state.
		County Code	West Virginia correctly used FIPS for the county codes in FY1999 Q1-Q2. In FY1999 Q3-Q4, however, the state incorrectly used a state-specific county code. The state used FIPS codes in FY 2000.

State	File Type	Record Type	Issue
WV	Eligibility	Dual Eligibility Flag	Approximately 75 percent of dual eligibles are coded with dual flag 09. The state is able to identify these individuals as dual eligibles, but cannot determine the basis of their dual eligibility.
		Health Insurance	MSIS data show a 17 percent increase in the number of enrollees with private health insurance from November 2001 to December 2001. The state believes this data to be correct. From October 1998 to May 1999, no one was reported to have any private health insurance. Beginning in June 1999, between 4-5 percent of eligibles are reported as having private health insurance.
		Managed Care	In September 1999, 728 enrollees had the managed care plan type field 9-filled by mistake. Because a managed care contract expired at the end of October 1999, managed care enrollment dropped off beginning in November 1999. West Virginia began to use a new set of managed care plans Ids in June 1999.
		MAS/BOE	Medicaid enrollment declined by about 30,000 persons from October 1998 to November 1998. Enrollment fell in most MAS/BOE groups, but fell most dramatically in MAS/BOE 34. WV reported a higher than expected (roughly 5 percent) number of eligibles in BOE 1 who are under age 65. The state believes this is caused by reporting all the persons in long-term care and QMB-only to BOE 1. This policy was corrected beginning in September 2002 data; however, it reoccurred in Q1 FY 2003, but was correct in Q2 Enrollment in MAS/BOE 11 and 12 is about 17 percent higher than the number of SSI recipients reported by SSA. This may be caused by persons receiving state supplemental SSI benefits for special needs administered by the state. Beginning in Q3 FY 2001, WV assigned state code RDF and RDFQ to women in the breast and cervical cancer program (BCCP). However, these eligibles were erroneously mapped to MAS/BOE 35 through Q4 FY 2002. In FY 2001 and FY 2002, WV mistakenly mapped 15- to 18-year-olds in state-specific eligibility groups FCDC and FCSC to MAS/BOE 35. These individuals should have been mapped to MAS/BOE 34. The state will fix this problem in its FY 2003 files. Between the end of FY 2000 and the beginning of FY 2001, West Virginia slightly adjusted their age sort for BOE 4 and BOE 5.

State	File Type	Record Type	Issue
WV	Eligibility	MAS/BOE	Beginning in FY 2001 Q4, West Virginia decided to change how eligibility for children was determined to insure that all children receive a 12-month continuous enrollment guarantee. This change resulted in a substantial enrollment shift from MAS/BOE 14 & 16 to MAS/BOE 34.
		TANF/1931	Effective FY 2001, the TANF flag is 9-filled for all eligibles. In FY1999 and FY 2000, the TANF flag was 9-filled for all eligibles in MAS/BOE 14-15. All other eligibles, including those in MAS/BOE 16-17, received TANF flag 1, indicating that they did not receive TANF benefits.

State	File Type	Record Type	Issue
WY	Claims	Capitation	There aren't any capitation claims as WY doesn't have managed care.
		Encounter	The state does not have any managed care.
		IP	The percent of claims without an accommodation code jumped from 0 percent to 8 percent in Q1 2003.
			The state does not use DRGs for reimbursement.
		LT	The admission date is missing.
			The diagnosis code is missing on most records.
			There aren't any claims for Type of Service 02 (MH for aged) in Q2-499.
	Eligibility	CHIP Code	Wyoming, which has an S-CHIP program, but not an M-CHIP program, is not reporting its S-CHIP eligibles into MSIS.
		Dual Eligibility Flag	In FY 2002 Q1-3, WY had a lower than expected proportion of Dual Eligibles with valid HIC numbers. The state fixed the problem in FY 2002 Q4.
			From FY1999Q1-FY 2001Q3, Wyoming assigned dual flag 09 to about 35 percent of its dual population, a higher proportion than expected. Beginning in FY 2001Q4, the state had system enhancements, which allowed them to identify this population as SLMB+ (dual flag = 04).
		Managed Care	Wyoming has no managed care.
		MAS/BOE	In Q4 FY 2002, 1400 enrollees in state group B05 (BCCPT women) were assigned to MAS/BOE 35. They should have been assigned MAS/BOE 3A. In addition, some individuals in state group D05 (maternal dental care) were mapped to MAS/BOE 51 in error. They should have been mapped to MAS/BOE 00, since this is a state-funded program.
		Private	The number of enrollees with private insurance increased in FY 2002 Q4, apparently because the file was submitted later than usual, and more data had become available at the time of submission.
		TANF/1931	Wyoming TANF data is not reliable. The state plans to 9-fill the TANF flag in the future.